Federal Register

Tuesday,
November 21, 2000

# Part VII

# Department of Labor

## Pension and Welfare Benefits Administration

**29 CFR Part 2520**

**Amendments to Summary Plan Description Regulations; Final Rule**

**DEPARTMENT OF LABOR**

**Pension and Welfare Benefits Administration**

**29 CFR Part 2520**

**RIN 1210–AA69; RIN 1210–AA55**

## Amendments to Summary Plan Description Regulations

**AGENCY:** Pension and Welfare Benefits Administration, Labor.

**ACTION:** Final rule.

**SUMMARY:** This document contains a final rule amending the regulations governing the content of the Summary Plan Description (SPD) required to be furnished to employee benefit plan participants and beneficiaries under the Employee Retirement Income Security Act of 1974, as amended (ERISA). These amendments implement information disclosure recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, as set forth in their November 20, 1997, report, ''Consumer Bill of Rights and Responsibilities.'' Specifically, the amendments clarify benefit, medical provider, and other information required to be disclosed in, or as part of, the SPD of a group health plan and repeal the limited exemption with respect to SPDs of welfare plans providing benefits through qualified health maintenance organizations (HMOs). In addition, this document contains several amendments updating and clarifying provisions relating to the content of SPDs that affect both pension and welfare benefit plans. This document also adopts in final form certain regulations that were effective on an interim basis implementing amendments to ERISA enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This final rule will affect employee pension and welfare benefit plans, including group health plans, as well as administrators, fiduciaries, participants and beneficiaries of such plans.

**DATES:** The amendments contained herein will be effective January 20, 2001. Except as otherwise provided, the amendments contained herein will be applicable as of the first day of the second plan year beginning on or after January 22, 2001.

**FOR FURTHER INFORMATION CONTACT:** Nalini Close, Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, U.S. Department of Labor, Washington, DC (202) 219–8521. This is not a toll-free number.

**SUPPLEMENTARY INFORMATION:**

### A. Background

On September 9, 1998, the Department published in the **Federal Register** (63 FR 48376) proposed amendments to 29 CFR 2520.102–3 and 2520.102–5, governing the content of the Summary Plan Description (SPD). A number of these amendments were proposed to implement recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry for improved disclosure by group health plans. The Commission's recommendations were set forth in its November 20, 1997 report, entitled ''Consumer Bill of Rights and Responsibilities.'' The Department also proposed several additional amendments to the SPD requirements intended to generally update and clarify the information required to be disclosed by welfare and pension plans.

Other amendments affecting the SPD requirements were published in the **Federal Register** on April 8, 1997 (62 FR 16979). These amendments, published as interim rules, served to implement amendments to ERISA's disclosure rules enacted as part the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The interim rules addressed certain content requirements for SPDs of group health plans and the furnishing of summaries of material reductions in covered services or benefits.

After consideration of the public comments received on both the proposed and the interim rules referenced above, the Department is adopting final rules affecting the content of SPDs (§ 2520.102–3), the limited exception for SPDs of welfare plans providing benefits through a qualified HMO (§ 2520.102–5), and the furnishing of summaries of material reductions in covered services or benefits by group health plans (§ 2520.104b–3).[1] A discussion of the specific amendments and the public comments follow.

### B. Amendments Relating to the Content of SPD

*1. Section 2520.102–3 (d)—Type of Plan*

Section 2520.102–3(d) currently requires plan administrators to specify in the summary plan description the type of welfare or pension plan they administer. In an effort to update that requirement, the Department proposed adding ''ERISA section 404(c) plans'' to the list of examples of types of pension plans and ''group health plans'' to the list of examples of types of welfare plans. One commenter expressed the view that the specific disclosures required under the regulation section governing section 404(c) plans (29 CFR 2550.404c–1(b)) should be adequate to inform participants and beneficiaries as to the nature of the plan and that, in some instances, the relief provided by section 404(c) may not extend to the entire plan. Other commenters suggested adding categories of plans to the list of examples, such as defined contribution plans, 401(k) plans, ''cash balance'' plans, etc. Upon consideration of these comments, the Department has, for purposes of the final regulation, decided to retain ''ERISA section 404(c) plan'' as an example in the list of types of pension plan, and to further add ''defined contribution plan,'' ''401(k) plan,'' and ''cash balance plan'' to that list. The list of examples is not intended to be exhaustive. Rather, section 2520.102–3(d) requires plan administrators to clearly communicate in the SPD information to participants and beneficiaries about the type of plan in which they participate and the features of such plan. In this regard, the Department notes that where section 404(c) is intended to apply to only certain aspects of a plan or where participants have the right to direct only certain investments in their account, such information should be communicated in the SPD in a clear, understandable manner. There were no comments raising concerns regarding the addition of ''group health plan'' as an example of welfare plan. Accordingly, that change is being adopted as proposed.

With regard to cash balance plans, the Department notes that two recent reports issued by the General Accounting Office (GAO) recommend changes to the SPD requirements that the GAO believes will serve to better inform participants and beneficiaries covered by such plans, or involved in a conversion to such a plan, of their rights and benefits under the plan.[2] The

[1] Rules governing the use of electronic media for distribution of SPD and similar documents will be published separately. In this regard, the Department intends to address the interim rule in 29 CFR 2520.104b–1(c) regarding the use of electronic media for furnishing SPDs, SMMs and updated SPDs to participants in group health plans in conjunction with the promulgation of a final rule on the use of electronic communications and recordkeeping technologies by employee benefit plans generally (*See* 64 FR 4506, January 28, 1999).

[2] See ''CASH BALANCE PLANS—Implications for Retirement Income'' (GAO/HEHS–00–207, dated September 29, 2000) and ''PRIVATE PENSIONS—Implications of Conversions to Cash Balance Plans'' (GAO/HEHS–00–185, dated September 29, 2000). Both GAO reports are available for viewing at www.gao.gov. The GAO's recommendations were for the Department to amend the disclosure regulations under ERISA to require that SPDs/

Department notes that the requirements governing the content of SPDs currently require the disclosure of information regarding a pension plan's requirements concerning eligibility for participation and benefits; a statement of conditions that must be met for eligibility to receive benefits; a summary of the benefits; circumstances that may result in ineligibility, loss of denial of benefits that a participant might otherwise reasonably expect the plan to provide on the basis of the description of benefits; and a description of the service required to accrue full benefits.[3] The Department further notes that the required information must be sufficiently comprehensive to reasonably apprise the plan's participants and beneficiaries of their rights and obligations under the plan and must be written in a manner calculated to be understood by the average plan participant.[4] The Department believes that the foregoing SPD provisions require a reasonably comprehensive and clear description of the provisions of a cash balance plan and how a prior conversion may have affected benefits that classes of participants may have reasonably expected the plan to provide. In this regard, the Department encourages sponsors of cash balance plans to review their SPDs to ensure compliance with current disclosure requirements. The Department, however, also shares the concerns raised by the GAO and agrees that more needs to be done to ensure that participants fully understand plan changes and the impact of such changes on their benefits under the plan. In this regard, the Department invites the views of interested persons on whether, and to what extent, changes to the SPD requirements would help ensure better communications with participants and beneficiaries about a cash balance plan and cash balance plan conversions. The Department also invites views on whether standardized language should be develop for the disclosure of such information to participants and beneficiaries. Suggestions for such language also are invited.

*2. Section 2520.102–3(j)—Eligibility for Participation and Benefits*

a. Procedures Governing QDRO and QMCSO Determinations

The Department proposed to amend § 2520.102–3(j)(1) to require that the SPD of a pension plan include either a description of the plan's 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. Similarly, the Department proposed amending paragraph (j)(2) to require that the SPD of group health plans include either a description of the plan's 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. The Department did not receive any comments requesting modification of these provisions; accordingly, these amendments are being adopted as proposed.

b. Pension Plan Disclosures

A number of commenters suggested that paragraph (j)(2) of § 2520.102–3 be changed to expressly require plan administrators to explain in pension plan SPDs the difference between the plan's requirements for eligibility to participate in a plan and the requirements for eligibility to receive benefits. These commenters stated that many participants in pension plans do not understand that satisfying eligibility requirements to participate in a plan does not necessarily mean that the participants are necessarily vested in the benefits provided by the plan. The current regulation requires that pension plan SPDs describe ''the plan's provisions relating to eligibility to participate in the plan, such as age or years of service requirements,'' and include ''a statement describing any other conditions which must be met before a participant will be eligible to receive benefits.'' Accordingly, it is the Department's view that the current regulation already requires that SPDs include a description, written in a manner calculated to be understood by the average plan participant, both of the requirements for eligibility to participate in a plan and of any additional conditions for eligibility to receive benefits. The Department, therefore, has determined that the requested clarification is not necessary.

c. Group Health Plan Disclosures

In responding to recommendations of the Health Care Commission, the Department proposed amending paragraph (j) of § 2520.102–3 to add a new subparagraph (3) clarifying the information that must be included in the SPD of a group health plan.[5] Specifically, subparagraph (3), as proposed, would require that the SPD of a group health plan describe: any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary will be responsible; any annual or lifetime caps or other limits on benefits under the plan; the extent to which preventive services are covered under the plan; whether, and under what circumstances, existing and new drugs are covered under the plan; 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 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 or specialty medical care; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan. Subparagraph (3) also provided that, in the case of plans with provider networks, the listing of providers may be furnished to participants and beneficiaries as a separate document, provided that the SPD contains a general description of the provider network and indicates that provider lists are furnished, without charge, in a separate document. In discussing the new subparagraph (3) in the preamble to the proposal, the Department expressed its view that the information more specifically delineated in the new subparagraph is already required to be disclosed pursuant to paragraph (j)(2) of § 2520.102–3, and that the amendment is merely intended to remove any ambiguity as to the disclosure

SMMs include: (i) a clear statement regarding the difference between the hypothetical account balance and the accrued benefit payable at normal retirement age under the cash balance plan; (ii) specific information about the impact timing of interest crediting has on deferred pension benefits for terminating workers; (iii) standardized language providing plan participants with their rights to contact PWBA and/or IRS if they are unable to understand the information provided and the relevant addresses and telephone numbers necessary for such contacts; (iv) a clear statement regarding the hypothetical nature of cash balance accounts, including that employees do not own the accounts and how such accounts differ from any defined contribution accounts an employer may also provide; and (v) a clear statement identifying the potential of the conversion to reduce future pensions accruals and early retirement benefits and under what circumstances such reductions are likely to occur.

[3] See: 29 CFR 2520.102–3(j), (l), and (n), respectively.

[4] See: 29 CFR 252.102–2(a).

[5] The term ''group health plan'' is defined in ERISA section 733(a).

requirements applicable to group health plans.

The Department received a number of comments relating to the requirements of proposed paragraph (j)(3). While many commenters agreed that much of the information delineated in the proposal is currently provided to participants and beneficiaries, a number of the commenters indicated that the information is not provided as part of an SPD. In this regard, commenters expressed concern that requiring specific detailed information relating to covered drugs, preventive services, cost-sharing provisions, and provider networks to be included in the SPD itself will be burdensome and costly to plans and not helpful for participants and beneficiaries. Some commenters indicated that having to amend SPDs to reflect frequent changes in specific benefits, such as the addition of new drugs, medical tests or devices, would also increase burdens and costs for plans. Other commenters expressed concern about having to provide all plan participants and beneficiaries with an SPD containing all the required disclosures when the plan provides different insurance or HMO options or different premium or cost-sharing provisions applicable to different categories of participants.

Under ERISA, the SPD is the primary vehicle for informing participants and beneficiaries about their rights and benefits under the employee benefit plans in which they participate. It is the view of the Department, therefore, that the SPD is the appropriate vehicle for providing participants and beneficiaries the information described in proposed paragraph (j)(3). It is important to note, however, that the Department did not intend paragraph (j)(3) to be construed as requiring the SPD to list each and every drug, test, device, or procedure covered by a group health plan. Rather, paragraph (j)(3) is intended to ensure that SPDs adequately inform participants and beneficiaries whether and under what circumstances the benefits referenced in paragraph (j)(3) will or will not be covered by the plan, and to direct participants and beneficiaries as to where additional information may be obtained, free-of-charge, about plan coverage of a specific benefit, i.e., a particular drug, treatment, test, *etc.* It is the view of the Department that paragraph (j)(2) of § 2520.102–3 continues to govern the required disclosure of detailed schedules of benefits, including schedules and listings of specific preventive services, drugs, tests, devices, procedures, and other benefits described in (j)(3), by group health plans. In this regard, § 2520.102–3(j)(2) provides, among other things, that ''[i]n 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.''

The Department also believes that its current law and regulations provide group health plans with sufficient flexibility so that they will not have increased burdens and costs resulting from having to amend SPDs to reflect frequent changes in specific benefits, such as the addition of new drugs, medical tests or devices. Rather, to the extent that there is a material modification in the terms of the plan or a change in the information required to be included in the SPD, ERISA section 104(b)(1) and the Department's regulations allow the administrator to furnish participants covered under the plan and beneficiaries receiving benefits with a summary of material modification, or SMM.

A few commenters requested that Department define specific itemized terms, such as ''preventive services'' and ''provider network.'' Because the meaning of such terms or concepts may vary from plan to plan, the Department believes that, in the context of describing covered benefits, such terms are best defined by reference to applicable plan provisions, rather than by regulation. Accordingly, the Department has not adopted these suggestions.

With regard to descriptions of group health plan provisions requiring preauthorization or utilization review as a condition to obtaining a benefit or service under the plan, the Department notes that, while only a summary of these provisions is required, the summary must be sufficient to apprise participants and beneficiaries of their rights and obligations under such provisions. With regard to the disclosure of cost sharing information, the Department notes that, while specific premium amounts would not have to be disclosed in the SPD, the SPD must clearly communicate the circumstances and extent to which participants and beneficiaries will be liable under the plan for premiums, deductibles, copayments, etc. Deductibles, copayments, benefit caps or limits on the benefits payable under the plan should be set forth in sufficient detail to reasonably enable participants and beneficiaries to assess their responsibility for medical care, hospital and other costs under the plan.

For the above reasons, the Department does not believe that requiring inclusion of the benefit information described in paragraph (j)(3) will either impose undue burdens on plans or undermine the usefulness of the SPD for plan participants and beneficiaries. To the contrary, the Department believes that inclusion of such information in the SPD is necessary to ensure that participants and beneficiaries are provided basic information concerning their plan's coverage of preventive medical services, drugs, tests , devices, etc., even if more detailed information concerning specific benefits is available on request.

The Department continues to believe, however, that, unlike schedules and listings of specific benefits that may be furnished upon request, complete listings of network providers should be furnished automatically to each participant and beneficiary. The Department believes that, where the availability of specific medical services or benefits under a plan may depend in whole or in part on knowing the specific service provider from whom services may be obtained, the selection of a service provider becomes a particularly significant benefit decision. The Department believes that, under such circumstances, participants and beneficiaries will be in the best position to evaluate and assess their medical provider options when they can review a complete listing of the providers available to them under the terms of the plan, rather than having to inquire on a service-by-service or provider-by-provider basis. For this reason, the Department is retaining the requirement that detailed provider lists be furnished automatically, without charge, to participants. The Department recognizes, however, that requiring all providers to be listed in an SPD may undermine the usefulness of SPDs as a disclosure document. The Department, therefore, is also retaining the proposed provision in paragraph (j)(3) permitting the network provider listings to be furnished in a separate document, provided that the SPD contains a general description of the provider network and, as noted, that provider lists are furnished automatically, without charge.

In response to commenter concerns about having to provide participants and beneficiaries with an SPD containing detailed benefit, premium, network provider, and other information that may not be equally relevant to all participants and beneficiaries, the Department notes that plan

administrators may utilize different SPDs for different classes of participants and beneficiaries, as described at 29 CFR 2520.102–4. In general, the regulation provides that where an employee benefit plan provides different benefits for various classes of participants and beneficiaries, the plan administrator may fulfill the requirement to furnish an SPD by furnishing each class of participant and beneficiary a copy of the SPD appropriate to that class. The regulation further provides that, while the SPD may omit information not applicable to the class of participants and beneficiaries to which it is furnished, the SPD must clearly identify on the first page of text the class of participants and beneficiaries for which the SPD was prepared and the plan's coverage of other classes. It is the view of the Department that where a plan has varying premium structures or benefits for different classes of participants and beneficiaries, different SPDs can be prepared and furnished in accordance with § 2520.102–4. For example, for purposes of § 2520.102–4, participants and beneficiaries may be classified by the benefit coverages they select under the plan (e.g., fee-for-service option or HMO option), thereby permitting separate SPDs to be prepared for each coverage option available under the plan.

*3. Section 2520.102–3(1)—Disclosure of Plan Termination Information*

The Department proposed to amend paragraph (1) of § 2520.102–3 to incorporate principles set forth in Technical Release 84–1 and to clarify the application of those principles to plan amendments. Specifically, the proposal would require that SPDs include the following information: (1) A summary of any plan provisions governing the authority of the plan sponsor or others to terminate the plan or to eliminate, in whole or in part, benefits under the plan, and the circumstances, if any, under which the plan may be terminated and benefits amended or eliminated; (2) 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 of the plan; and (3) a summary of any plan provisions governing the allocation and disposition of assets of the plan upon termination of the plan.

Several commenters argued against adopting this provision on the basis that it would be difficult for plan administrators to anticipate and describe in an SPD all the possible circumstances under which plans may be terminated or benefits eliminated. The Department does not view the proposed amendment of paragraph (1) as requiring an exhaustive listing or description of every circumstance that might result in the elimination of benefits or termination of the plan. Rather, SPDs should include a clear, understandable summary of the sponsor's authority under the plan, as well as limitations thereon, to eliminate benefits or terminate the plan. The level of detail provided in the SPD, however, may vary depending on the nature of the plan and the plan provisions involved. The Department continues to believe, as it has since the issuance of Technical Release 84–1, that the disclosure of the information relating to the circumstances under which benefits might be eliminated or the plan terminated, and the effects of such actions on benefits, is of significant importance to participants and beneficiaries. For this reason, the Department is adopting, without change, the proposed amendment to paragraph (1) of § 2520.102–3.

A few commenters suggested that the regulations should prohibit conflicts between provisions of the SPD and the plan document by requiring the use of clear terminology and definitions, prohibiting the use of disclaimers in SPDs, and providing that ambiguous SPD provisions will be interpreted against the drafter. To the extent these comments concern the understandability of SPDs to plan participants and beneficiaries, the Department believes that its current general standards on style and format of SPDs in 29 CFR 2520.102–2 are appropriate and further regulatory guidance is not necessary. Some of these comments, such as the request to prohibit ''disclaimers'' in SPDs and establishing a rule calling for interpreting ambiguous provisions in SPDs against the drafter, raise issues that are beyond the scope of these SPD regulations.

Several commenters suggested that the Department clarify the requirement regarding disclosure of subrogation provisions in a plan's SPD. It is the Department's view that subrogation, reimbursement, and other provisions of a plan that may serve to eliminate, reduce, offset or otherwise adversely affect the amount of benefits to which a participant or beneficiary is entitled must be disclosed in the SPD pursuant to § 2520.102–3(l). Similarly, it is the view of the Department that, for purposes of satisfying § 2520.102–3(l), the SPD must include a description of any fees or charges that may be imposed on a participant or beneficiary, or their individual account, as a condition to receiving a benefit, inasmuch as any such fee or charge may, directly or indirectly, serve to reduce the benefits the participant or beneficiary might otherwise reasonably expect to receive. Paragraph (l) has been clarified in this regard.

*4. Section 2520.102–3(m)—PBGC Coverage*

Section 2520.102–3(m) requires pension plan SPDs to include a statement indicating whether benefits of the plan are insured under Title IV of ERISA and, if insured, a description of the pension benefit guaranty provisions of Title IV and a statement indicating that further information can be obtained from the plan administrator or the Pension Benefit Guaranty Corporation (PBGC). The regulation provides that a SPD is deemed to meet the requirements of paragraph (m)(2) if it includes a model statement included in the regulation. The Department proposed to amend the model statement in accordance with changes provided by the PBGC to more accurately reflect the benefits guaranteed under Title IV, as well as update the information relating to the PBGC.

A commenter stated that the model statement was not appropriate for use in SPDs of multiemployer plans because a broader range of circumstances can give rise to a plan termination and the level of guaranteed benefits may be substantially below the level of benefits promised under the plan. In response to this comment, the PBGC prepared separate model statements for single-employer plans and multiemployer plans, and the Department modified the proposal to include the model statement for single-employer plans in paragraph (m)(3) and the model statement for multiemployer plans in paragraph (m)(4).

*5. Section 2520.102–3(o)—COBRA Rights*

Under the proposal, paragraph (o) of § 2520.102–3 would be amended to address the requirement that participants and beneficiaries in group health plans subject to the COBRA continuation coverage provisions of Part 6 of Title I of ERISA be provided information concerning their rights and obligation under those provisions.

Two commenters expressed concern about having to provide detailed COBRA information in the SPD. One of the commenters suggested permitting the information to be furnished in a separate document, like the disclosures permitted with respect to QDRO and QMCSO determination procedures. The COBRA provisions confer important substantive rights upon participants and beneficiaries concerning the continuation of their health plan coverage. For this reason, the Department continues to believe that participants and beneficiaries should be informed about these rights, and their obligations with respect to the exercise of these rights, in the summary plan description. The Department, therefore, is adopting the proposed amendment of paragraph (o) of § 2520.102–3 without change.

One commenter requested a clarification as to whether the section 606(a)(1) COBRA notice provided through the SPD should be provided at the time the participant first becomes covered under the plan or when the participant becomes eligible for COBRA continuation coverage. Pursuant to ERISA section 104(b)(1), and the Department's regulations issued thereunder, an administrator must distribute an SPD within 90 days of an individual's becoming a participant or beneficiary under the plan. ERISA section 606(a)(1), however, requires group health plans to provide covered employees and spouses, if any, with notification of their COBRA rights at the time of commencement of coverage under the plan, i.e., when the individual becomes a participant or beneficiary. As noted in the preamble to the proposed regulation, the Department has taken the position that the disclosure obligation under section 606(a)(1) will be satisfied by furnishing to the covered employee and spouse, at the time coverage commences under the plan, an SPD that includes the COBRA continuation coverage information required by section 606(a)(1).[6]

Two commenters raised issues concerning spousal notification. One commenter inquired whether hand delivery of an SPD with COBRA information to a participant at a worksite location with written instructions to share the SPD with the spouse would satisfy the section 606(a)(l) disclosure requirement. The other commenter expressed concern that including COBRA information in the SPD may lead some to conclude that spousal notification is not required. The mere fact that COBRA information is required to be set forth in the SPD does not relieve group health plan administrators from their obligation to provide notice to an employee's covered spouse under 606(a)(1). The Department, however, has taken the position that where a spouse's last known address is the same as the covered employee's, a single mailing of the required COBRA disclosure (which could be in the form of an SPD), addressed to both the employee and the spouse, will constitute good faith compliance with the COBRA notice requirements of section 606(a)(1) (*See* Technical Release No. 86–2). It is the view of the Department that, in the absence of specific contrary regulations, in-hand delivery to an employee at his or her worksite location of an SPD containing COBRA information would not constitute adequate notice to the spouse of that employee for purposes of section 606(a)(1).

*6. Section 2520.102–3(q)—Funding Medium Information for Group Health Plans*

On April 8, 1997, the Department published in the **Federal Register** (62 FR 16970) an amendment to paragraph (q) of § 2520.102–3 implementing statutory changes to the SPD disclosure requirements enacted as part of the Health Insurance Portability and Accountability Act of 1996. The amendment was intended to ensure that SPDs clearly inform participants and beneficiaries about the role of health insurance issuers in their group health plan, particularly in those cases where the plan is self-funded and an insurer is serving as a contract administrator or claims payor, rather than as an insurer. In the preamble to the September 9, 1998, proposed SPD amendments (63 FR 48386), the Department noted that it intended to adopt paragraph (q) as a final regulation in conjunction with the adoption of other amendments to the SPD requirements.

One commenter suggested that paragraph (q) should require that SPDs include an explanation of the importance of whether health benefits provided by a plan are guaranteed by an insurer, including a disclosure that participants and beneficiaries in self-insured group health plans do not have access to the consumer protections afforded to participants and beneficiaries of plans utilizing state-licensed insurers and HMOs (for example, solvency requirements and governmental administrative assistance in the event of disputes over coverage). The Department does not believe that the SPD is the appropriate vehicle for comparing various types of funding arrangements, without regard to whether such arrangements are actually utilized by the plan. The Department, therefore, is adopting paragraph (q) of § 2520.102–3, without change and as it was adopted in interim form, as a final rule.

*7. Section 2520.102–3(s)—Claims Procedure Information*

The Department proposed to amend paragraph (s) of § 2520.102–3 to make clear that the claims procedure in the SPD of a group health plan must include any plan procedures for preauthorization, approval, or utilization review. The proposed amendment also made clear that a plan is not precluded from furnishing the plan's claims procedures as a separate document that accompanies the plan's SPD, provided that the separate document satisfies the style and format requirements of § 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. While commenters generally supported the provision allowing the plan's claims procedures to be provided in a separate document, a few commenters argued that, given the importance of the claims procedures to participants and beneficiaries, the full claims procedures should be required to be in the SPD.

The Department agrees that the procedures governing a plan's benefit claims and appeal processes are of critical importance to participants and beneficiaries. The Department also recognizes that requiring incorporation of detailed claims procedures in the SPD, which contains a wide variety of benefit-related information, may in some instances minimize the importance of the procedures or overwhelm some participants. It is the view of the Department that the proposed conditions for utilizing a separate document for purposes of disclosing a plan's benefit claims and appeals procedures will ensure that participants and beneficiaries receive clear and complete information about their plan's benefit claims procedures, while providing plan administrators the flexibility to choose which method of communication, integration in an SPD or furnishing a separate document with the SPD, will best serve their plan's participants and beneficiaries. The Department, therefore, is adopting the

[6] The Department is currently considering the issuance of additional guidance, in form of regulations, that would serve to clarify the information disclosure and notification requirements under the continuation coverage provisions of Part 6 of Title I, including the requirements of section 606(a)(1) of ERISA.

proposed amendment to paragraph (s) of § 2520.102–3 without change.

*8. Section 2520.102–3(t)—Statement of ERISA Rights*

The proposal would amend paragraph (t)(2) of § 2520.102–3 to improve and update the model statement of ERISA rights that plans may use to satisfy the requirement to furnish participants and beneficiaries with the statement of ERISA rights described in section 104(c) of the Act. Specifically, the Department proposed to amend the model statement to incorporate references to participant rights under the COBRA continuation provisions of Part 6 of ERISA and the portability provisions of Part 7 of ERISA. The proposal also would extend to all employee benefit plans the model statement changes applicable to group health plans on an interim basis as a result of amendments to ERISA enacted as part of the Health Insurance Portability and Accountability Act of 1996. It does so with the addition of a sentence to the model statement directing participants and beneficiaries who have questions about their ERISA rights to the nearest office of the Pension and Welfare Benefits Administration or the Division of Technical Assistance and Inquiries in Washington, D.C. Other changes to the statement include: modifying the reference of ''up to $100 a day'' to ''up to $110 a day,'' to reflect the fact the civil monetary amount under ERISA section 502(c)(1) has been increased to take inflation into account, as required by the Debt Collection Improvement Act of 1996; [7] clarifications to the language discussing the types of documents participants and beneficiaries have the right to examine and receive copies of upon request; the addition of a sentence indicating that issues involving the qualified status of domestic relations orders and medical child support orders may be resolved in Federal court; and clarifying the rights of participants and beneficiaries under the plan's claims procedures.

A number of commenters suggested that the style and readability of the model statement could be improved by, for example, varying font sizes and using headings and indented text. Other commenters suggested that the Department include information concerning the availability of Departmental assistance in obtaining SPDs and copies of plan documents, while others requested that the Department include a statement urging participants and beneficiaries to contact their plans before filing complaints with the Department or suing regarding problems with claim denials or issues on benefit entitlements.

In response to these comments, the Department has added headings to the model statement that are intended to make the statement easier to read. Administrators are encouraged to explore other steps that might be taken to enhance readability, without compromising or undermining the substantive information provided in the model statement. The Department also has modified the proposed model statement to include provisions informing participants and beneficiaries that they may obtain copies of annual reports (Form 5500s) filed for their plan from the Public Disclosure Room of the Pension and Welfare Benefits Administration (PWBA) and a notice that assistance is available from PWBA's regional offices in obtaining from plan administrators documents under which the plan is established or operated.

With respect to the suggestion that participants be encouraged to contact their plans about claims and benefit issues prior to contacting the Department of Labor, the Department believes that language of the proposed statement—directing plan questions to the plan administrator—provides direction to plan participants without inhibiting their pursuing issues with the Department. Accordingly, no changes to the model statement are being made in this regard.

*9. Section 2520.102–3(u)—Newborns' and Mothers' Health Protection Act Disclosure*

On September 9, 1998, the Department published in the **Federal Register** (63 FR 48372) a revised interim rule setting forth the information required to be disclosed in the SPD concerning the provisions of the Newborns' and Mothers' Health Protection Act (Newborns' Act), codified at section 711 of ERISA. A concern was expressed to the Department that the interim rule in § 2520.102–3(u) required all Title I group health plans to include information in their SPDs about federal law requirements under the Newborns' Act while section 711(f) provides an exception from those requirements for health insurance coverage in certain states. Specifically, section 711(f) provides that the requirements of section 711 shall not apply with respect to health insurance coverage if a state law regulating the coverage: (1) requires such coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section; (2) requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations; or (3) requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to by made by) the attending provider in consultation with the mother. The commenter expressed concern that participants and beneficiaries could be confused by an SPD disclosure describing federal law requirements in situations where only state law applies.

The Department agrees that plans that are exempt from the federal law requirements of section 711 because state law requirements apply should be able to focus their SPD disclosure on the applicable state law requirements for hospital length of stay following newborn deliveries. The final rule therefore modifies the requirement in § 2520.102–3(u) to provide that, for a group health plan, as defined in section 733(a)(1) of the Act, that provides maternity or newborn infant coverage, the SPD must contain a statement describing the federal or state law requirements applicable to the plan or any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child. The final rule makes it clear that if federal law applies in some areas in which the plan operates and state laws apply in others, the SPD must describe the federal and state law requirements that apply in each area covered by the plan. The final rule also sets forth a model statement that group health plans subject to section 711 of the Act may use to comply with paragraph (u) of this section relating to the required description of federal law requirements.

**C. Repeal of Limited Exemption for SPDs of Plans Providing Benefits Through a Federally Qualified HMO**

The proposal would repeal the limited exemption, at 29 CFR 2520.102–5, for SPDs of welfare benefit plans providing benefits through a qualified HMO, as defined in section 1310(d) of the Public Health Act, 42 U.S.C. 300e–9(d). Such SPDs are not required to include the information described in §§ 2520.102–3(j)(2), (l), (q) and (s), provided certain conditions are met. Several commenters objected to the repeal of § 2520.102–5, expressing concern that this change would result in

[7] *See* 62 FR 40696 (July 29, 1997).

voluminous and unhelpful SPDs. Specifically, they stated that HMOs already provide much of the information described in §§ 2520.102–3(j)(2), (l), (q), and (s) directly to participants and beneficiaries, that a typical group health plan could provide a choice among benefits under a large number of different HMOs, and, in such a case, the plan's SPD would have to include extensive and, for some participants and beneficiaries, potentially irrelevant information on each of the HMOs. Commenters also argued that HMO information changes frequently, which would require frequent amendment to SPDs. The elimination of § 2520.102–5 would, according to those commenters, result in increased plan expenses. Other commenters complained that it would be unfair to require plan administrators to be responsible for providing information on HMOs to participants and beneficiaries because typical HMO contracts preclude the employer from having access to such information.

The Department continues to believe that, given the legislative and other changes affecting the operation of group health plans since the adoption of § 2520.102–5 in 1981,[8] the information required to be disclosed through the SPD and summaries of changes thereto are as important to participants and beneficiaries electing coverage through a federally qualified HMO as any other group health plan participant or beneficiary. The Department is not convinced that the disclosure obligations otherwise applicable to federally qualified HMO are adequate to ensure that participants and beneficiaries receive both timely and useful information.

Moreover, as noted earlier, plan administrators may, pursuant to § 2520.102–4, utilize different SPDs for different classes of participants within a single plan. Where a group health plan offers multiple benefit options, it is the view of the Department that participants and beneficiaries may be classified by the benefit coverages they elect under the plan (e.g., fee-for-service option or HMO option), thereby permitting separate SPDs to be prepared pursuant to § 2520.102–4 for each coverage option available under the plan. The Department believes that this flexibility permits plan administrators to avoid the problems raised by commenters, while ensuring that participants and beneficiaries receive relevant information about their coverage. With respect to the comments expressing concern about administrators being responsible for the information provided about federally qualified HMOs, the Department notes that administrators currently are responsible for the information provided to participants and beneficiaries under non-federally qualified HMO coverage and benefit options offered by group health plans. For the reasons discussed above, the Department continues to believe that extending that same responsibility to the information provided about federally qualified HMOs is appropriate.

Finally, certain commenters argued that the proposal exceeded the Department's authority because it is the option to join the HMO that is the plan benefit and not the medical coverage provided by the HMO. Therefore, the commenters contended, the only HMO information that the Department can require to be included in the SPD is information regarding eligibility to join the HMO. The Department disagrees with this view. As the Department stated in the preamble to its 1981 rule providing limited relief to welfare benefit plans that include membership in a qualified HMO as an option, ERISA applies to a plan that offers benefits listed under section 3(1) of ERISA, regardless of whether the benefits are offered through a qualified HMO or otherwise. *See* 46 FR 5882 (January 21, 1981).

As a result, the Department is adopting the proposal without change.

**D. Amendments Relating to Furnishing Summaries of Material Reductions in Covered Services or Benefits**

Section 104(b)(1) of ERISA requires, among other things, that the administrator furnish to each participant, and each beneficiary receiving benefits under the plan, copies of modifications in the terms of their plans and changes in the information required to be included in the SPD not later than 210 days after the end of the plan year in which the change is adopted. Section 101(c)(1) of HIPAA amended ERISA section 104(b)(1) to provide that, in the case of any modification or change that is a ''material reduction in covered services or benefits provided under a group health plan,'' participants and beneficiaries must be furnished the summary of such modification or change not later than 60 days after the adoption of the modification or change, unless the plan sponsor provides summaries of modifications or changes at regular intervals of not more than 90 days.

On April 8, 1997, the Department published an interim rule (62 FR 16985) amending 29 CFR 2520.104b–3 by adding a new paragraph (d) to implement the statutory change to section 104(b)(1). Specifically, section 2520.104b–3(d)(1) provides that summaries of any modification to the plan or change in the information required to be included in the SPD that is a material reduction in covered services or benefits must be furnished by administrators of group health plans to each participant covered under the plan, and each beneficiary receiving benefits under the plan, not later than 60 days after the date of adoption of the modification or change. Section 2520.104b–3(d)(2) provides that the 60-day period for providing such summaries does not apply to any participant or beneficiary who would reasonably be expected to be furnished such summary in connection with a system of communication maintained by the plan sponsor or administrator, with respect to which plan participants and beneficiaries are provided information concerning their plan, including modifications and changes thereto, at regular intervals of not more than 90 days. Section 2520.104b–3(d)(3)(i) defines a ''material reduction in covered services or benefits'' to mean any modification to the plan or change in the information required to be included in the SPD that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average plan participant to be an important reduction in covered services or benefits. To facilitate compliance, paragraph (d)(3)(ii) set forth a listing of modifications or changes that generally would constitute a ''reduction in covered services or benefits.''

One commenter expressed confusion over the requirement to provide these disclosures to ''beneficiaries receiving benefits under the plan'' given the fact that pursuant to 29 CFR 2520.104b–2 only beneficiaries receiving benefits under a pension plan are required to be furnished a summary plan description. While the included language regarding beneficiaries tracks the language of § 2520.104b–3(a), the Department agrees with the commenter that the reference to ''beneficiaries receiving benefits under the plan'' appears to conflict with other regulatory provisions that indicate that beneficiaries receiving benefits under a welfare plan are excepted from the disclosure requirement. In addition to the provisions in § 2520.104b–2 noted by the commenter, the Department notes that 29 CFR 2520.104b–1(a), governing the furnishing of documents required to be furnished by direct operation of law

[8] *See* 46 FR 5884, January 21, 1981.

(such as SPDs and SMMs), specifically excepts from that disclosure obligation ''beneficiaries under a welfare plan.'' Accordingly, the Department is eliminating the reference to ''each beneficiary receiving benefits under the plan'' from paragraph (d) of § 2520.104b–3. The Department, nonetheless, would be interested in receiving comments from interested persons on whether, and under what circumstance, the current regulations should be amended to require disclosure of SPD and related information to beneficiaries receiving benefits under a welfare plan.

With respect to the provision in the interim rule defining ''material reduction in covered services or benefits,'' one commenter suggested that the ''average plan participant'' standard contained in the definition is too strict for chronically ill patients. Another commenter recommended that the Department adopt a standard that is more objective and easier to ascertain. The ''average plan participant'' standard has been the standard that plan administrators have used for more than twenty years in determining whether an SPD satisfies the requirements of § 2520.102–2(a). That general standard is warranted because of the variety of plan participants and the impossibility of adopting a standard that accounts for all of the circumstances of individual plan participants. Therefore, it is the Department's view that the ''average plan participant'' standard should be used in determining whether a modification or a change is a material reduction in covered services or benefits.

**E. Applicability Dates**

The Department expressed its view in the proposal that the information delineated in paragraph (j)(3), applicable to group health plans, paragraph (j)(1) and paragraph (l) of § 2520.102–3 is currently required to be disclosed under the disclosure framework of ERISA. Accordingly, the Department considered the proposed addition of the new paragraph (j)(3) and the amendment of paragraphs (j)(1) and (l) as clarifications of existing law, rather than new disclosure requirements. With regard to the other proposed amendments, the Department proposed to require plans to comply with the new requirements no later than the earlier of: (1) The date on which the first summary of material modification (or updated SPD) is required to be furnished participants and beneficiaries following the effective date of the amendments or (2) the first day of the second plan year beginning after the effective date of the final rule.

Several commenters disagreed with the Department's view of paragraphs (j)(3), (j)(1) and (l) of § 2520.102–3, and requested additional time to comply with these paragraphs of the regulation. Commenters also asked the Department to coordinate the applicability date of these regulations with that of the Department's final regulations governing plans' benefit claims procedures to make it possible for plans to coordinate the revision of their claims procedures with the revision of their SPDs. Additionally, one commenter suggested coordinating the applicability date of this regulation with the date that qualified plans subject to ERISA must be restated under the Small Business Jobs Protection Act (SBJPA) and the Taxpayer Relief Act of 1997 (TRA '97). The commenter expressed concern that if the applicability date is not coordinated, many plans may have to revise their SPDs twice in a very short period of time leading to confusion and needless expenditure of plan assets.

The Department continues to adhere to its view that the information delineated in paragraphs (j)(3), (j)(1) and (l) of § 2520.102–3 is currently required to be disclosed under the existing disclosure framework of ERISA. In response to the other comments, however, the Department has determined to modify the proposal and to adopt a single applicability date for the new SPD disclosures in the proposal. Specifically, plans will be required to comply with the new SPD content requirements being adopted in this regulation no later than the first day of the second plan year beginning after the effective date of the final rule.

Finally, the interim rules that are being finalized in this notice are already effective, and accordingly, a special applicability date is not required. Rather, the special applicability dates for the interim rules codified in paragraph (v) of § 2520.102–3 are obsolete and, accordingly, are being removed as part of this final rule.

**Economic Analysis Under Executive Order 12866**

Under Executive Order 12866, the Department must determine whether the regulatory action is ''significant'' and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the order defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of Executive Order 12866, it has been determined that this action is consistent with the President's priorities with respect to ensuring that all participants in group health plans receive understandable information about their plans, as described in the report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry entitled, ''Consumer Bill of Rights and Responsibilities.'' The added cost estimated to be associated with the amendments to existing regulations implemented in this final rule total $208 million in 2002, the year in which these amendments are expected to be applicable for the majority of plans. Therefore, this notice is ''significant'' and subject to OMB review under Sections 3(f)(1) and 3(f)(4) of the Executive Order.

Accordingly, the Department has undertaken to assess the costs and benefits of this regulatory action. The Department's assessment, and the analysis underlying that assessment, is detailed following the statements concerning the Regulatory Flexibility Act and the Paperwork Reduction Act.

The Consumer Bill of Rights and Responsibilities states that, ''Consumers have the right to receive accurate, easily understood information about their health plans, facilities and professionals to assist them in making informed health care decisions.'' The purpose of this final rule is to implement this principle within the framework of existing disclosure requirements under ERISA, based on the September 9, 1998 proposal and comments received in response, as well as to generally update the disclosure requirements for both welfare and pension plans.

Currently available information supports the conclusion that many group health plans already provide the majority of information identified in these amendments, including benefits and limitations, whether drug formularies are used and how drugs and

procedures are deemed experimental, information on cost sharing, and appeal procedures.[9] Comments received in response to the proposal support this conclusion as well, although they point out, and the respondents to the GAO survey included in its report on the Commission's disclosure recommendations agree, that some group health plans rely on a combination of documents to make disclosures. However, it is understood that while many plans may conform with or exceed a minimum standard of information disclosure, some portion of the very large number of group health plans do not currently meet this standard. To the extent that plans do not currently provide the required information, they will be caused by these amendments to revise their disclosure documents and distribute additional or modified information to participants.

Although the amendments pertinent to pension plans are substantially more limited, many are expected to require certain additions or revisions to their disclosure documents as a result of this final rule. It is anticipated that these revisions will be readily made either in connection with routine updating of these documents, or through distribution of an SMM.

Based on the applicability date of the final rule, and an assumption as to current compliance, it is estimated that approximately 30 percent of pension plans and 50 percent of group health plans will be required to modify and distribute revised disclosure materials by the end of calendar year 2002. The expenses expected to be associated with the preparation and distribution of these additions and revisions are relatively easily quantified, and constitute the estimated cost of the regulation.

The Department estimates the cost of these amendments to be $47 million in 2001, rising to $208 million in 2002, falling to $24 million in 2003 and in each year thereafter. The peak cost in 2002 reflects $32 million for the preparation of 155,000 different SPDs describing 1.2 million pension and welfare plans and $176 million for the distribution of those SPDs to 36 million participants. The variation in cost over this period reflects the interaction of the final rule's effective date with the distribution of the recordkeeping years used by pension and health plans years across the months of the year. Because more than half of plans use a calendar plan year, the final rule will be effective for a majority of plans in 2002. It is also assumed that plans that would be making changes to their disclosure materials prior to 2002, even absent the final rule, will elect to make both those changes and revisions necessary as a result of this final rule at the same time.

The benefits of the regulation are more qualitative in nature, but are nevertheless significant for participants and beneficiaries, plan sponsors, and the performance of the health care system in general. The regulation will ensure that participants have better access to more complete information about their benefit plans. Such information is important to participants' ability to understand and secure their rights under their plans at critical decision points, such as when illness arises, when they must decide whether to participate in a plan, or when they must determine which benefit package option might be most suitable to individual or family needs. Participants generally desire health care benefits which support their health and limit their exposure to financial risk. In 1998, 131 million participants and dependents had private employment-based health care coverage [10], for which they contributed an average of $123 per month for family coverage, and $29 per month for single coverage. [11] Adherence to disclosure standards will enable participants to make effective choices concerning this substantial investment, taking into consideration their knowledge of their own health and financial circumstances, and accurate information about their plans.

These amendments will also assist plan administrators to meet their statutory disclosure obligations with greater certainty, which is expected to be helpful given the many changes that have occurred since guidance on the required content of SPDs was originally issued in 1977. In addition to their compliance with statutory and regulatory disclosure obligations, plan sponsors are also concerned about the pricing and availability of appropriate coverage options. Private employers play a significant role in the acquisition of health care coverage. Over 64 percent of the total population had private employment-based health care coverage in 1998, for which employers contributed an average of $318 per active employee. [12] Better information will also enhance the ability of plan sponsors to purchase products that are appropriate to both their needs and the health and financial needs of their employees.

Information will promote the efficiency of the competitive market through which this array of needs is met. There is wide-spread agreement that the efficiency of the health care market can be improved if purchasers, consumers, and patients are provided with better information. Improved information is expected to promote efficiency by fostering competition based on considerations beyond pricing alone, and by encouraging providers to enhance quality and reduce costs for value-conscious consumers. Complete disclosure will limit competitive disadvantages that arise when, for example, incomplete or inaccurate information on different benefit option packages is used for decision making purposes. Information disclosure also promotes accountability by ensuring adherence to standards.

Equally importantly, information disclosure under the SPD regulation, if combined with additional disclosures pertaining to plan and provider performance, and with other health system reforms that promote efficient, competitive choices in the health care market, could yield even greater benefits. The Lewin report points out that such reformed systems, as exemplified by CalPERS and other examples of privately sponsored ''managed competition,'' have successfully reduced health care inflation, producing savings that dwarf the cost of these amendments and other pro-competitive reforms. Better information, clarified guidance to plan administrators, and improved market efficiency thus constitute the benefits of the regulation.

The Department believes, therefore, that the benefits of this regulation will substantially outweigh its costs. The disclosures it describes are a component of evolving legislative, regulatory, and

[9] *See* ''Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and Internal Appeals,'' The Lewin Group, November 15, 1997; and ''CONSUMER HEALTH CARE INFORMATION—Many Quality Commission Disclosure Recommendations Are Not Current Practice'' (GAO/HEHS–98–137, April 1998). The GAO report indicates that only about half of the information recommended by the Commission to be provided to consumers is currently provided by large purchasers. However, it is information on health plan features such as covered benefits, cost-sharing, access to emergency services and specialists, and appeal processes which is currently routinely provided, while information about health care facilities and the business relationships and financial arrangements among health professionals, and quality and performance measures is not typically provided. Although the Commission's recommendations go beyond current practice, the provisions of this final rule are considered to be reasonably consistent with the current practices of the large purchasers surveyed by GAO.

[10] March 1999 Current Population Survey

[11] Average employee and employer monthly contribution figures as reported in, ''Health Benefits in 1998,'' KPMG.

[12] ''National Survey of Employer-sponsored Health Plans,'' Foster Higgins, 1998.

voluntary private reforms that together are already improving health care market efficiency.

**Regulatory Flexibility Act**

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and which are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a final rule will not have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires the agency to present a final regulatory flexibility analysis describing the impact of the rule on small entities at the time of publication of the notice of final rulemaking. Small entities include small businesses, organizations, and governmental jurisdictions.

For purposes of analysis under the RFA, PWBA continues to consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis of this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which cover fewer than 100 participants. Under section 104(a)(3), the Secretary may also provide for simplified annual reporting and disclosure if the statutory requirements of part 1 of Title I of ERISA would otherwise be inappropriate for welfare benefit plans.

PWBA believes that assessing the impact of this rule on small plans is an appropriate substitute for evaluating the effect on small entities. Because this definition differs from the definition of small business which is based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (5 U.S.C. 631 *et seq.*), PWBA solicited comments on the use of this standard for evaluating the effects of the proposal on small entities. One commenter was concerned that prior to adopting the proposed size standard, the Department first consult with the Office of Advocacy of the Small Business Administration (SBA) and provide an opportunity for public comment. The Department consulted with the SBA regarding its proposed size standard prior to publication of the proposed amendments to the SPD regulation and its proposed regulation relating to employee benefit plan claims procedures under ERISA, which was also published on September 9, 1998 (63 FR 48390). The SBA has agreed with PWBA's use of the proposed alternate size standard, indicating in the claims regulation and other contexts that the Department has provided a reasonable justification for its definition. We are using the same justification in connection with this final rule. No other comments were received with respect to this size standard. A summary of the final regulatory flexibility analysis based on the 100 participant size standard is presented below.

This regulation applies to all small employee benefit plans covered by ERISA. Employee benefit plans with fewer than 100 participants include 693,000 pension plans, 2.8 million health plans, and 3.4 million non-health welfare plans (mainly life and disability insurance plans).

The final rule amends the Department's existing SPD regulation, which implements ERISA's statutory SPD requirements. Both ERISA and the existing regulation require plans to provide SPDs that include certain information and adhere to certain formats to participants according to statutory schedules. The compliance requirements assumed for purposes of this regulation consist of revising SPDs and preparing SMMs consistent with the regulation's requirements, and distributing them to participants consistent with the regulation's applicability date. An extensive list of authorities may be found in the Statutory Authority section, below.

The objective of this revised regulation is to ensure that employee benefit plan participants and beneficiaries have complete and up-to-date information about their plans. Certain provisions pertaining to group health plans are being implemented in accordance with recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry in its November 20, 1997 report entitled ''Consumer Bill of Rights and Responsibilities.''

The Department believes that revising an SPD or describing changes in an SMM requires a combination of professional and clerical skills. Professional skills pertaining to employee benefits law and plan design and administration are needed to draft language for inclusion in an SPD, and therefore an average rate which takes into account wage rates and overhead for attorneys and financial managers ($56 per hour) is used to estimate the costs of needed professional services. Clerical skills are needed to type, assemble and format SPD materials, and to reproduce the materials and either mail or transmit materials electronically to participants. A wage and overhead rate of $21 per hour is used to estimate the cost of these functions.

The Department has estimated that about 30 percent of pension plans and 50 percent of group health plans will be required to revise and distribute SPDs or SMMs in response to this final rule, regardless of plan size. The cost for small plans is moderated by the fact that small welfare plans, the number of which is approximately 2.75 million, are known to make use of a relatively small number of providers of service to design plans and provide disclosure materials, which tends to increase administrative efficiency and lower costs for small plans.

The cost of these amendments for small plans may be borne in a variety of ways, depending upon a plan's governing rules, cost sharing provisions of the plan, administrative practices, the terms of contracts in place with administrators and insurers, and the magnitude of the actual compliance cost. Insurers and administrators may choose to absorb some costs to maintain competitive products, or may pass on administrative or premium charges to policyholders. Sponsors may elect to finance such cost increases, or may pass them along to participants. The ultimate allocation of these costs cannot be accurately predicted.

The Department's assessment of the regulation's costs and benefits, and the extent to which the Department has minimized the impact on small entities, is detailed below, following the discussion of the Paperwork Reduction Act. The Department estimates that the added cost to small plans of complying with the regulation will amount to $17 million in 2001, $38 million in 2002, and $4 million in 2003 and subsequent years. The peak year cost of $38 million in 2002 consists of $3 million to prepare 124,000 unique SPDs describing 1.1 million plans, and $35 million to distribute these SPDs to 8 million participants. These costs amount to $34 per affected small plan and $5.08 per affected small plan participant. By contrast, the added cost to large plans in 2002 is estimated at $170 million, or $5,549 per affected large plan and $5.93 per affected large plan participant. The principal reason for the substantially greater per-plan cost for large plans is the cost of distribution to greater numbers of plan participants.

The cost estimates for small plans are modest in large part because the features of the majority of small health and other welfare plans are chosen from a finite menu of products offered by insurers and HMOs. The insurers and HMOs

prepare the majority of SPD material, describing their small plan products, and provide that material to their small plan customers. Thus, the cost of preparing a relatively small number of unique SPDs is spread over a far larger number of small plans.

Finally, in promulgating this final rule, the Department has minimized the economic impact on small entities by adopting a delayed applicability date that lets plan administrators avoid the largest component of the cost of a regulatory change in the SPD content requirements (i.e., distribution expenses) by allowing them to incorporate the required revisions into the periodic SPD updates that they would otherwise be distributing as part of their usual and customary business practices.

The Department is not aware of any rules or requirements which overlap or duplicate the requirements of this final rule. State insurance statutes typically require that certain disclosures be made to policyholders, but these disclosures either do not overlap with the requirements described in this regulation, or a single disclosure package can be used to satisfy both state and federal requirements.

**Paperwork Reduction Act**

On September 9, 1998, the Pension and Welfare Benefits Administration published a Notice of Proposed Rulemaking (September 9 proposal) concerning Amendments to Summary Plan Description Regulations (63 FR 48376), which included a request for comments on its information collection provisions. That proposal, if adopted as proposed, would have revised the information collection request (ICR) included in existing regulations relating to the content of Summary Plan Descriptions under ERISA. Also on September 9, 1998, the Department submitted the revised ICR to OMB for review and clearance under the Paperwork Reduction Act of 1995 (PRA 95), and solicited public comments concerning the revision of the information collection request (ICR) included in the proposal.

Further, the Department submitted a revised ICR to OMB for emergency clearance in connection with its Interim Rule Amending Summary Plan Description for the Newborns' and Mothers' Health Protection Act (63 FR 48372, September 9, 1998). OMB subsequently approved the request for emergency clearance; OMB's consideration of the revisions proposed in connection with the September 9 proposal was deferred to the publication of the final rule and submission to OMB of the ICR included in the final rule. The Department had also previously submitted and received OMB's approval of the Summary Plan Description ICR as amended in connection with the Interim Rules Amending ERISA Disclosure Requirements for Group Health Plans (62 FR 16979, April 8, 1997). This final rule implements the information collection provisions of the September 9, 1998 proposal, as modified in the final rule, along with those of the April 8, 1997 Interim Final Rules as they pertain to SPDs under ERISA.

An additional revision to the Summary Plan Description ICR was subsequently made in connection with PWBA's Proposed Rule on the Use of Electronic Communication and Recordkeeping Technologies by Employee Pension and Welfare Benefit Plans (64 FR 4506, January 28, 1999). This proposal included guidance on the use of electronic technologies to satisfy notice and disclosure requirements of ERISA. OMB approved the submission of this revised ICR which addressed electronic communication of SPDs on June 1, 1999.

OMB has approved the ICR included in this Notice of Final Rule relating to Amendments to Summary Plan Description Regulations. A copy of the ICR, with applicable supporting documentation, may be obtained by contacting the Department of Labor, Departmental Clearance Officer, Ira Mills, at (202) 693–4122. (This is not a toll-free number.)

**Statute and Existing Regulations**

Pursuant to ERISA section 101(a)(1), the administrator of an employee benefit plan is required to furnish a Summary Plan Description (SPD) to each participant covered under the plan and each beneficiary who is receiving benefits under the plan. The SPD is required to be written in a manner calculated to be understood by the average plan participant, and must be sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan. To the extent that there is a material modification in the terms of the plan or a change in the information required to be included in the SPD, ERISA requires that the administrator furnish participants covered under the plan and beneficiaries receiving benefits with a summary of such changes (Summary of Material Modification, or SMM).

ERISA section 102(b) describes the types of information specifically required to be included in the SPD. The Department has previously issued guidance concerning the required contents of summary plan descriptions in regulations at 29 CFR 2520.102–3.

**Proposed Revisions and Final Rule**

As described in the September 9, 1998 publication, revisions proposed for §§ 2520.102–3 and 2520.102–5 would have modified the required contents of summary plan descriptions in a number of ways that would be expected to affect the nature and burden of the information collection under PRA 95. The proposal included amendments to §§ 2520.102–3(j) and (s) and § 2520.102–5 that were designed to implement certain recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry as incorporated in the Consumer Bill of Rights with respect to ERISA covered group health plans. Specifically, the proposal provided that group health plans would not be deemed to have satisfied content requirements unless they had provided understandable information in their SPDs concerning any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary would be responsible; any annual or lifetime caps or other limits on benefits under the plan; the extent to which preventive services would be covered under the plan; whether, and under what circumstances, existing and new drugs would be covered under the plan; whether, and under what circumstances, coverage would be provided for medical tests, devices and procedures; provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage would be provided for out-of-network services; any conditions or limits on the selection of primary care providers or providers of speciality medical care; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan.

The April 8, 1997 Interim Final Rules implemented changes finalized here with respect to the content and timing of disclosures by group health plans, specifically, the timing of providing participants with summaries of material reductions in coverage, disclosure of the role of health insurance issuers, and disclosure of the availability of assistance from the Department.

As explained earlier in this preamble, after consideration of comments received in response to the proposal, the

Department has determined that it is appropriate to adopt the proposed and interim final regulations essentially as published, with certain clarifications, and modification of the proposed applicability date. Although the underlying requirements are on the whole unchanged from the proposal, the burden hour and cost estimates have been significantly modified in response to public comment.

Specifically, changes in burden estimates have resulted from adjustments to certain of the Department's underlying assumptions. For example, commenters indicated that the 17 hours estimated for a plan which must incorporate the changes recommended in the Consumer Bill of Rights was understated. Although comments indicate that many plans in fact presently provide the recommended Consumer Bill of Rights disclosures, the Department finds these comments persuasive with respect to those plans that have not yet undertaken to provide the recommended disclosures, and has adjusted this assumption to an average of 25 hours.

In response to specific comments, the Department has also added previously omitted estimated printing costs (an average of $2.25 per SMM or SPD for pension plans, and $3.50 for group health plans) to the cost of distributing SMMs and SPDs, although this change does not affect the incremental cost of this final rule except to the extent that more printing is likely to be required as a result of these amendments. Health plan materials are assumed to require an additional $1.00 in printing costs in those circumstances in which SPDs have not yet been revised to include the Consumer Bill of Rights disclosures.

The assumed printing costs are lower than the $7 to $12 unit printing costs reported by the commenters because it is assumed that some plans will be able to comply by providing SMMs, which would be substantially less costly to print. The use of lower estimates is also intended to account for the fact that some portion of the total printing cost would be likely to be incurred as a usual business practice in the absence of the statutory or regulatory requirements as to SPD content. This assumption change has a very significant impact on the total operating and maintenance costs for this ICR, more than doubling the aggregate cost of the regulation.

Assumptions with respect to the rate of hourly wages have been adjusted in response to comments upward from the $50 blended professional rate and $11 clerical rate previously used in the estimates for the proposal to $56 and $21, respectively. Adjustments were also made based on updated data for enrollment in health plans, numbers of pension plans, and rates of growth in wage and salary employment.

Numerous comments indicating that plans already comply with the proposed revisions, although not necessarily in exactly the manner commenters construed the proposal to require (as to matters such as the level of detail, or including numerous benefit options in a single SPD) support the Department's original view that some portion of plans will be unaffected by these amendments because they already comply. At the time of the proposal, however, and in the absence of specific evidence on the rate of current compliance in the record, the Department used the conservative estimate that 100% of plans would be required to revise SPDs or issue substantial SMMs. The Department has now revised this assumption to reflect the estimate that in the aggregate only about 30 percent of pension plans and 50 percent of group health plans will be required to revise SPDs or issue substantial SMMs as a result of changes implemented by this final rule.

In addition to commenters' questions about the appropriateness of the assumptions used in the Department's analysis of the proposal, a number of commenters also expressed concern that certain revisions proposed would generate additional and unnecessary expense, and would limit the usefulness of the SPD. Commenters indicated, for example, that the SPD was not an appropriate vehicle for communicating time-sensitive or frequently changing information because other communication vehicles already provide the needed information promptly and efficiently. Others stated that requiring a significant amount of detail in an SPD on such matters as provider networks, premium and cost sharing rates, coverage of experimental or investigational treatments and drugs, would be costly and unnecessary, and would result in more frequent change to maintain current information in such detail.

The Department has discussed its responses to these comments in detail earlier in this preamble. In general, the Department has clarified that certain required disclosures, such as claims procedures, provider listings or extensive benefit schedules, may be provided separately provided that the SPD directs participants and beneficiaries to where additional information can be found. The Department has also indicated that it did not intend the provisions of the proposal to be construed to require an SPD to list every drug, test, device or procedure, nor necessarily the dollar amount of premium or employee contributions required for coverage, so long as a summary or description is included that is adequate to communicate participants' rights under the plan, and the manner in which they will become responsible for expenses incurred under the plan. The Department also notes that plan administrators may under existing regulations prepare separate SPDs for different classes of participants, and may make use of an SMM to inform participants of material changes in the information required to be included in the SPD. Each of these options may have a moderating effect on the cost of preparing and distributing disclosure materials in accordance with these final rules.

Because the Department viewed the revised disclosure requirements as proposed as requiring a more limited level of detail than apparently understood by these commenters, on the basis of these clarifications, the Department believes that SPDs amended pursuant to the requirements of the final rules will provide participants and beneficiaries with an appropriate level of detail and not result in unwarranted ongoing expense. As a consequence, the analysis of the impact of these amendments has not been changed, except as to the assumptions specifically identified above.

With respect to the proposed elimination of the exemption from SPD requirements for federally qualified HMOs, commenters stated that causing a single SPD to be prepared to include information currently provided by HMOs to enrollees but consistent with the style, format and content requirements of the regulation would result in significant costs and duplication of effort. Commenters also indicated that causing all HMO options and other benefit options to be described in a single SPD would result in unnecessary costs and unusably large and complex documents. More than one commenter expressed the view that the increased costs arising from this requirement would ultimately result in elimination of HMO options currently available to participants and beneficiaries.

The Department has responded to concerns that the inclusion of all options in a single document would result in unwarranted costs, impractical disclosure vehicles, and more limited benefit options by noting that plan administrators may use different SPDs for different classes of participants, including those classes identified by their elected benefit coverages.

Furthermore, in the Department's view, the information required to be incorporated in the SPD is important to participants and beneficiaries electing coverage through a federally qualified HMO, even though an expense may be associated with bringing the HMO disclosure material into compliance. Accordingly, the Department has not modified its cost estimates in response to these comments.

The resulting burden estimates are summarized below. A more detailed description of the assumptions and methodology underlying these estimates will be found below in the Analysis of Costs.

*Agency:* Pension and Welfare Benefits Administration.

*Title:* Regulations Regarding Required Contents of Summary Plan Descriptions for Employee Benefit Plans (Final Amendments to Summary Plan Description Regulations).

*OMB Number:* 1210–0039.

*Affected Public:* Individuals or households; Business or other for-profit; Not-for-profit institutions.

*Frequency of Response:* On occasion.

*Total Respondents:* 943,779 (2001); 1,790,161 (2002).

*Total Responses:* 52,771,000 (2001); 88,911,000 (2002).

*Estimated Burden Hours:* 710,134 (2001); 1,117,801 (2002).

*Estimated Annual Costs (Operating and Maintenance):* $243,226,000 (2001); $400,056,000 (2002).

Persons are not required to respond to the revised information collection unless it displays a currently valid OMB control number.

**Analysis of Cost**

The Department performed a comprehensive, unified analysis to estimate the costs of the regulation for purposes of compliance with Executive Order 12866, the Regulatory Flexibility Act, and the Paperwork Reduction Act. The methods and results of that analysis are summarized below, along with a discussion of comments received on the analysis included in the original proposal.

To estimate the costs, it was necessary to estimate the number of SPDs in the ERISA-covered employee benefit plan universe, the frequency with which those SPDs are updated and distributed, and the number of participants to whom they must be distributed. It was also necessary to make certain assumptions about the cost of preparing and distributing SPDs, in particular the cost of bringing SPDs into compliance with the regulation's provisions. The Department separately estimated the baseline cost of its existing SPD regulation and the incremental cost of this final rule.

In response to its proposed rulemaking, the Department received a number of comments bearing on the estimates of the economic impact of the regulation. Several commenters stated the general view that the SPD was not an appropriate vehicle for communicating time-sensitive or frequently changing information because other communication vehicles already in use provide the needed information promptly and efficiently. Others indicated that requiring a significant amount of detail in an SPD on such matters as provider networks, premium and cost sharing rates, coverage of experimental or investigational treatments and drugs, would be costly and unnecessary, and would result in more frequent change in the future. Commenters also indicated that the speed with which they would be required to make the very substantial revisions to SPDs would increase the cost to comply.

With respect to the elimination of the exemption from SPD requirements for federally qualified HMOs, commenters stated that causing a single SPD to be prepared to include the information currently provided by HMOs to enrollees but consistent with the style, format and content requirements of the regulation would result in significant costs and duplication of effort. Commenters also indicated that causing all HMOs and other benefit options to be described in a single SPD would result in unnecessary costs and unusably large and complex documents. More than one commenter expressed the view that the increased costs arising from this requirement would ultimately result in elimination of HMO options currently available to participants and beneficiaries.

Other comments indicated that in light of the very significant new requirements, the Department's cost estimates were substantially understated, despite the commenters' assertions that much of the information is already provided. Concerns were expressed about the time required and timing of the required revisions, the hourly wage rates, and the omission of printing costs from the Department's estimates. The Department has considered these comments in view of commenters' apparent interpretations of the requirements of the proposed rules, and has adjusted a number of its assumptions as specifically detailed below to address comments on required resources, wage rates, and printing costs. A revision was also made to the final rule's effective date to address issues of flexibility and efficiency in plan administrators' implementation of required revisions.

In response to concerns raised about the potential for the proposed revisions to generate additional and unnecessary expense, and to result in SPDs of limited usefulness, the Department has earlier in this preamble expressed its views concerning the level of detail required to be included in an SPD. In general, the Department has clarified that certain required disclosures, such as claims procedures, provider listings or extensive benefit schedules, may be provided separately, provided that the SPD directs participants and beneficiaries to where additional information can be found. The Department has also indicated that it did not intend the provisions of the proposal to be construed to require an SPD to list every drug, test, device or procedure, nor necessarily the dollar amount of premium or employee contributions required for coverage, so long as a summary or description is included that is adequate to communicate participants' rights under the plan, and the manner in which they will become responsible for expenses incurred under the plan. The Department also notes that plan administrators may under existing regulations prepare separate SPDs for different classes of participants, and may make use of an SMM to inform participants of material changes in the information required to be included in the SPD. Each of these options may have a moderating effect on the cost of preparing and distributing disclosure materials in accordance with these final rules.

Because the Department viewed the revised disclosure requirements as proposed as requiring a more limited level of detail than apparently understood by these commenters, on the basis of these clarifications, the Department believes that SPDs amended pursuant to the requirements of the final rules will provide participants and beneficiaries with an appropriate level of detail and not result in unwarranted ongoing expense. As a consequence, the analysis of the impact of these amendments has not been changed, except as to the assumptions specifically identified below.

With respect to the proposed elimination of the exemption from SPD requirements for federally qualified HMOs, commenters stated that causing a single SPD to be prepared to include information currently provided by HMOs to enrollees but consistent with the style, format and content requirements of the regulation would

result in significant costs and duplication of effort. Commenters also indicated that causing all HMO options and other benefit options to be described in a single SPD would result in unnecessary costs and unusably large and complex documents. More than one commenter expressed the view that the increased costs arising from this requirement would ultimately result in elimination of HMO options currently available to participants and beneficiaries.

The Department has responded to concerns that the inclusion of all options in a single document would result in unwarranted costs, impractical disclosure vehicles, and more limited benefit options by noting that plan administrators may use different SPDs for different classes of participants, including those classes identified by their elected benefit coverages. Furthermore, in the Department's view, the information required to be incorporated in the SPD is important to participants and beneficiaries electing coverage through a federally qualified HMO, even though an expense may be associated with bringing the HMO disclosure material into compliance. Accordingly, the Department has not modified its cost estimates in response to these comments concerning the federally qualified HMO disclosure requirements.

As a result, the basic framework and assumptions used in the analysis are generally unchanged. However, certain specific assumptions have been revised in response to comments received, or based on the availability of more recent or more complete data. The modification of the applicability date should allow many plans a somewhat longer period of time to come into compliance, and lessen their overall cost to comply by providing flexibility in their use of resources. The Department has increased its assumption concerning the amount of professional time required to effect compliance with the Consumer Bill of Rights disclosure provisions, and has altered its original assumption as to the proportion of plans that currently comply based on a number of comments indicating current compliance in substance. Professional and clerical wage rates have been adjusted upward, and an estimate of previously omitted printing costs has been included. Details of the analysis of costs follow.

The Department's estimates of both the pension and health universes have been updated based on current data, the overall effect of which is the use of slightly larger numbers of pension plans, and substantially higher numbers of health plans than used for estimates of the impact of the proposal (specifically, 2.8 million plans compared with the 2.5 million plans at the time of the proposal). The Department estimated the number of plans, SPDs and the number of participants based on 1995 Form 5500 Series data, the March 1999 Current Population Survey (CPS), the 1996 Medical Expenditure Panel Survey (MEPS), and 1995 Census Bureau data on firms and establishments. Each pension plan is estimated to maintain one SPD, and Form 5500 data demonstrates the number of pension plans and participants. The number of welfare plans is more difficult to determine because the majority of welfare plans are exempt from the requirement to file Form 5500 due to their having fewer than 100 participants and being unfunded or fully insured. The 1996 data from MEPS on health plans offered by establishments was converted from establishments to firms using 1995 Census Bureau data, and then converting the estimate of firms to plans using Form 5500 pension data estimates on the number of multiemployer plans. The number of participants was generated using March 1999 CPS data inflated to 2002 using BLS employment projections. Form 5500 data for 1995 was used to distribute the CPS aggregate between large and small plans.

With respect to group health plans, the number of SPDs is estimated to be smaller than the number of plans because small plans typically buy standard products from vendors. In addition, individual plan sponsors often sponsor more than one plan and/or offer more than one kind of benefit (such as retirement and disability) under a single plan, but describe two or more of their plans or benefit types in a single SPD. The Department assumes that pension plans and health plans (or products) maintain separate SPDs, but that non-health welfare benefits are either offered together with health benefits as part of unified welfare plans or are maintained as separate plans but described along with accompanying health plans in a single combined SPD.

Pursuant to these assumptions, the Department estimates that the universe includes a total of 693,000 unique pension plan SPDs. The estimate of 84,900 unique health plan SPDs is assumed to encompass all other welfare plan SPDs. The estimated number of unique health plan SPDs has been increased for the purposes of analysis of this final rule based on updated and more detailed information on the numbers of plans, rates of self-funding, and numbers of group health plan issuers of insurance policies.

With respect to the frequency of updating and distributing SPDs, plans filing the Form 5500 indicate whether they amended and distributed their SPDs in the preceding year. About 30 percent of plans so report. This figure is interpreted to represent a baseline level of SPD modification and distribution activity. The amendments implemented by this final rule are not expected to change the baseline rate of SPD modification for pension plans, but are expected to cause some health plans to make changes to SPDs sooner than they would otherwise have made them.

The Department generally assumes that preparing a revised SPD requires four hours of combined professional and clerical time, priced at $56 and $21 per hour, respectively. Previous assumptions were $50 and $11. The Department assumes that distributing an SPD consumes two minutes of clerical labor at $21 per hour, plus $2.25 for printing, materials, and mailing (or electronic dissemination) for pension plans and $3.50 for printing, materials, and mailing (or electronic dissemination) for welfare plans. This amounts to $2.95 per pension SPD and $4.20 per welfare plan SPD distributed. As noted earlier, printing costs were not previously estimated, and have been included here in response to comments.

The Department estimates the baseline cost to prepare and distribute SPDs under the current regulation at $218 million in 2001, $224 million in 2002, and approximately $230 million in 2003 based on projected enrollment growth. Total cost in a typical baseline year such as 2001 includes $46 million to prepare 208,000 unique SPDs, and $172 million to distribute copies to 51 million participants.

The Department separately estimated the cost of revisions to SPDs that plan administrators may undertake to update their SPDs following adoption of final amendments of the SPD content requirements. This cost is separate from the baseline cost attributable to normal SPD revisions, such as those made pursuant to plan amendments. Plans preparing SPDs solely to comply with the final rule would incur only the costs attributable to those revisions deemed necessary to comply with the provisions of the final rule, while plans simultaneously revising their SPDs for other reasons would incur this additional cost plus the baseline unit cost.

With respect to pension plans, the Department assumes that preparing an SPD to comply with the final rule requires 30 minutes of professional time

at a rate of $56 per hour. The time and expense associated with distributing each SPD are assumed to be unchanged from the baseline.

To estimate the per-unit cost to prepare revised health plan SPDs, the Department originally drew on two studies of the cost to health plans to comply with the Consumer Bill of Rights, one cited earlier by The Lewin Group for the President's Commission, and one by Coopers and Lybrand for the Kaiser Family Foundation.[13] Excerpting and adjusting these studies' estimates to reflect the regulation's provisions, the Department essentially adopted the midpoint of these two studies' findings. With the addition of the small burden attributable to other provisions, the cost to prepare a health plan SPD to bring it into conformity with the regulation was originally estimated to require an average of approximately 18 hours at $50 per hour (17 hours for the Consumer Bill of Rights disclosures). Based on the comments received on this estimate, the Department has adjusted its assumptions concerning the time required to implement Consumer Bill of Rights disclosures where not previously implemented from an average of 17 hours to 25 hours, and the total time required to come into compliance with all health plan provisions of the final rule from an average of 18 hours to an average of about 27 hours. This adjustment is responsive to comments, and has the effect of giving the Lewin cost estimates greater weight in the analysis of the impact of this final rule. The resulting estimate takes into account a range of current compliance, based on comments received indicating that many plans already provide the required information, although not necessarily in the format the commenters construed the proposal to require, and the fact that some plans more nearly in compliance may choose to comply with an SMM, presumably lessening the cost of compliance. The average cost of preparation of group health plan disclosures is estimated at about $1,400 per unique SPD.

Numerous comments indicating that plans already comply with the proposed revisions, although not precisely in the manner commenters construed the proposal to require (as to level of detail, including numerous benefit options in a single SPD), support the Department's original view that some portion of plans will be unaffected because they already comply. At the time of the proposal, however, and in the absence of specific evidence of the rate of current compliance in the record, the Department used the conservative estimate that 100% of plans would be required to revise SPDs or issue substantial SMMs. The Department has now revised this assumption to reflect the estimate that in the aggregate 30 percent of pension plans and 50 percent of group health plans will be required to revise SPDs or issue substantial SMMs as a result of changes implemented by this final rule.

The Department assumed that the cost to distribute a group health plan SPD with the additional disclosures will rise in connection with the regulation, consuming an additional one minute of clerical time at $21 per hour and an additional $1.00 for materials and mailing or electronic distribution, for a total for $1.35 per SPD distributed.

The Department estimates the added cost attributable to this regulation to be $47 million in 2001 and $208 million in 2002. The peak incremental cost in 2002 includes $32 million to prepare 155,000 different SPDs describing 1.2 million pension and welfare plans, and $176 million to distribute those SPDs to 36 million participants.

Combining this added cost with the baseline cost attributable to the existing regulation, the total cost to prepare and distribute SPDs under the regulation amounts to $265 million in 2001, and $432 million in 2002. The peak cost in 2002 includes $78 million to prepare 321,000 SPDs describing 1.8 million plans, and $354 million to distribute those SPDs to 89 million participants.

The baseline, additional, and total costs associated with the final SPD regulation are summarized in the table below:

[In millions of dollars]

| Year | Baseline | Additional | Total |
|---|---|---|---|
| 2001 | $218,360,000 | $47,129,000 | $265,489,000 |
| 2002 | 223,949,000 | 208,070,000 | 432,019,000 |

Plans that are assumed for purposes of this analysis to prepare and distribute SPDs for the sole purpose of complying with the regulation have the option of complying by preparing and distributing SMMs instead, the choice likely depending on the extent of the changes required for the plan involved. Plans are expected to make use of an SMM to come into compliance when a moderate to small number of revisions are required, resulting in a relatively low cost to comply relative to an extensive revision of an SPD. As a result of its use of an assumption representing a midpoint between an SMM cost and an SPD cost, the Department's estimates of the costs to revise and distribute compliant disclosure materials in response to this regulation can be interpreted to account for the likelihood that some plans will elect to prepare and distribute SMMs.

**Executive Order 13132 Statement**

This final rule does not have federalism implications because it has no substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Section 514 of ERISA provides, with certain exceptions specifically enumerated, that the provisions of Titles I and IV of ERISA supercede any and all laws of the States as they relate to any employee benefit plan covered under ERISA. This final rule, therefore, does not affect the States or change the relationship or distribution of power between the national government and the States. Further, this final rule implements certain revisions to annual reporting and disclosure regulations which have been in effect in similar form for many years. The amendments incorporated in this final rule do not alter the fundamental requirements of the statute with respect to the reporting and disclosure requirements for employee benefit plans, and as such have no implications for the States or the relationship or distribution of power between the national government and the States.

[13] ''Estimated Costs of Selected Consumer Protection Proposals—A Cost Analysis of the President's Advisory Commission's Consumer Bill of Rights and Responsibilities and the Patient Access to Responsible Care Act,'' Coopers & Lybrand, LLP for the Kaiser Family Foundation, April, 1998.

**Unfunded Mandates Reform Act**

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), as well as Executive Order 12875, this rule does not include any Federal mandate that may result in expenditures by State, local, or tribal governments, but does include mandates which may impose expenditures of $100 million or more on the private sector. The basis for this statement is described in the analysis of costs for purposes of Executive Order 12866. Identification of the authorizing statute, and the assessment of the anticipated costs and benefits, and economic effect of this regulation are also presented elsewhere in this preamble.

In promulgating this final rule, the Department has adopted the least burdensome method of achieving the rule's objective of improving the information that participants and beneficiaries receive about their ERISA covered pension and welfare plans. The majority of the costs associated with the SPD arise from the distribution costs that must be incurred to comply with ERISA's requirement that plan administrators disclose certain information to participants and beneficiaries within specified time frames. Because plan administrators must communicate changes in the terms of the plan or other changes that affect the information required to be included in the SPD even absent any change in regulatory requirements, they periodically update and distribute SPD information to participants and beneficiaries as part of their usual and customary business practices. To ensure that the regulatory amendments being adopted as part of this final rule may be implemented by administrators in the least burdensome manner, the Department adopted a delayed applicability date that lets plan administrators avoid the largest component of the cost of a regulatory change in the SPD content requirements (*i.e.,* distribution expenses) by allowing them to incorporate the required revisions into the periodic SPD updates that they would otherwise be distributing as part of their usual and customary business practices.

**Small Business Regulatory Enforcement Fairness Act**

This final rule is subject to the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) (SBREFA), and is a major rule under SBREFA. Accordingly, this final rule has been transmitted to Congress and the Comptroller General for review.

**Statutory Authority**

This regulation is adopted pursuant to the authority in sections 101, 103, 104, 109, 110, 111, 504 and 505 of ERISA and under Secretary of Labor's Order No. 1–87, 52 FR 13139, April 21, 1987.

**List of Subjects in 29 CFR Part 2520**

Employee benefit plans, Employee Retirement Income Security Act, Group health plans, Pension plans, Welfare benefit plans.

For the reasons set forth above, Part 2520 of Title 29 of the Code of Federal Regulations is amended as follows:

1. The authority for Part 2520 continues to read as follows:

**Authority:** Secs. 101, 102, 103, 104, 105, 109, 110, 111(b)(2), 111(c), and 505, Pub. L. 93–406, 88 Stat. 840–52 and 894 (29 U.S.C. 1021–1025, 1029–31, and 1135); Secretary of Labor's Order No. 27–74, 13–76, 1–87, and Labor Management Services Administration Order 2–6.

2. Section 2520.102–3 is amended by removing paragraph (v), revising paragraphs (d), (j), (l), (m)(3), (o), (s), (t)(2), and (u), revising the last sentence of paragraph (q), and adding paragraph (m)(4) to read as follows:

**§ 2520.102–3 Contents of summary plan description.**

* * * * *

(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.

* * * * *

(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.

(1) For employee pension benefit plans, 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.

(2) For employee welfare benefit plans, 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.

(3) For employee welfare benefit plans that are group health plans, as defined in section 733(a)(1) of the Act, the summary plan description shall include a description of any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary will be responsible; any annual or lifetime caps or other limits on benefits under the plan; the extent to which preventive services are covered under the plan; whether, and under what circumstances, existing and new drugs are covered under the plan; 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 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 speciality medical care; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan. In the case of plans with provider networks, 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.

* * * * *

(l) For both pension and welfare benefit plans, 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. 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. 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).

(m) * * *

(3) A summary plan description for a single-employer plan 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 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.

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.

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 http://www.pbgc.gov.

(4) A summary plan description for a multiemployer plan will be deemed to comply with paragraph (m)(2) of this section if it includes the following statement:

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.

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.

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.

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.

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 http://www.pbgc.gov.

* * * * *

(o) In the case of a group health plan, 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.

* * * * *

(q) * * * 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.

* * * * *

(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.

(t) * * *

(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:

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:

**Receive Information About Your Plan and Benefits**

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 Pension and Welfare Benefit Administration.

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.

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.

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.

**Continue Group Health Plan Coverage**

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.

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.

**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 (pension, welfare) benefit or exercising your rights under ERISA.

**Enforce Your Rights**

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.

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.

**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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

(u) (1) For a group health plan, 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.

(2) In the case of a group health plan 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:

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).

**§ 2520.102–5 [Removed]**

3. Section 2520.102–5 is removed.

4. Section 2520.104b–3 is amended by revising the second sentence of paragraph (a), and paragraphs (d) and (e) to read as follows:

**§ 2520.104b–3 Summary of material modifications to the plan and changes in the information required to be included in the summary plan description.**

(a) * * * Except as provided in paragraph (d) of this section, the plan administrator shall furnish this summary, written in a manner calculated to be understood by the

average plan participant, not later than 210 days after the close of the plan year in which the modification or change was adopted. * * *

* * * * *

(d) *Special rule for group health plans.* (1) *General.* Except as provided in paragraph (d)(2) of this section, the administrator of a group health plan, as defined in section 733(a)(1) of the Act, shall furnish to each participant covered under the plan a summary, written in a manner calculated to be understood by the average plan participant, of any modification to the plan or change in the information required to be included in the summary plan description, within the meaning of paragraph (a) of this section, that is a material reduction in covered services or benefits not later than 60 days after the date of adoption of the modification or change.

(2) *90-day alternative rule.* The administrator of a group health plan shall not be required to furnish a summary of any material reduction in covered services or benefits within the 60-day period described in paragraph (d)(1) of this section to any participant covered under the plan who would reasonably be expected to be furnished such summary in connection with a system of communication maintained by the plan sponsor or administrator, with respect to which plan participants are provided information concerning their plan, including modifications and changes thereto, at regular intervals of not more than 90 days and such communication otherwise meets the disclosure requirements of 29 CFR 2520.104b–1.

(3) *''Material reduction''.* (i) For purposes of this paragraph (d), a ''material reduction in covered services or benefits'' means any modification to the plan or change in the information required to be included in the summary plan description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average plan participant to be an important reduction in covered services or benefits under the plan.

(ii) A ''reduction in covered services or benefits'' generally would include any plan modification or change that: eliminates benefits payable under the plan; reduces benefits payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases premiums, deductibles, coinsurance, copayments, or other amounts to be paid by a participant or beneficiary; reduces the service area covered by a health maintenance organization; establishes new conditions or requirements (*i.e.,* preauthorization requirements) to obtaining services or benefits under the plan.

(e) *Applicability date.* Paragraph (d) of this section is applicable as of the first day of the first plan year beginning after June 30, 1997.

* * * * *

Signed at Washington, D.C., this 15th day of November, 2000

**Leslie B. Kramerich,**

*Acting Assistant Secretary, Pension and Welfare Benefits Administration, U.S. Department of Labor.*

[FR Doc. 00–29765 Filed 11–20–00; 8:45 am]

BILLING CODE 4510–29–P