



FACTSHEET

NOVEMBER 2016

Workers' Right To Health Plan Information

The Employee Retirement Income Security Act (ERISA) governs approximately 2.3 million health benefit plans sponsored by private sector employers nationwide. These plans provide a wide range of medical, surgical, hospital and other health care benefits to some 143 million Americans.

Under ERISA, workers and their families are entitled to receive a Summary Plan Description (SPD). The SPD is the primary document that gives information about the plan, what benefits are available under the plan, the rights of participant and beneficiaries under the plan, and how the plan works.

Among other information, the SPD of health plans must describe:

- Cost-sharing provisions, including premiums, deductibles, coinsurance and copayment amounts for which the participant or beneficiary will be responsible
- 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 provider networks and whether, and under what circumstances, coverage is provided for out-of-network services
- Conditions or limits on the selection of primary care providers or providers of specialty medical care
- Conditions or limits applicable to obtaining emergency medical care
- Provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan
- Annual or lifetime caps or other limits on benefits under the plan. Note that under the Affordable Care Act, plans cannot set annual or lifetime limits on the dollar value of essential health benefits. For more information on what benefits are considered essential health benefits, visit Healthcare.gov.

The SPD must also explain how plan benefits may be obtained and the process for appealing denied benefits.

ERISA requires that SPDs be updated periodically. Furthermore, ERISA requires disclosure of any material reduction in covered services or benefits to participants and beneficiaries generally within 60 days of the adoption of the change through either a revised SPD or a Summary of Material Modification (SMM). Material changes that do not result in a reduction in covered services or benefits must be disclosed through an SMM or revised SPD not later than 210 days after the end of the plan year in which the change was adopted.

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Another source of information about your health plan is the Summary of Benefits and Coverage (SBC), a short, easy-to-understand document that summarizes key features of the plan, including covered benefits, cost-sharing provisions and coverage limitations. You should receive a copy of the SBC with your enrollment materials.

The Department's claims procedure regulation describes your right to get an answer from your health plan regarding your health benefit claim. The regulation protects you – providing for a timely response by describing the timeframes for a decision, providing for a fair process by describing the standards for a decision, and providing for meaningful disclosure by describing the notice and disclosure that you are entitled to receive from your plan. The Affordable Care Act provides additional rights and protections, including additional rights related to internal claims and appeals and a requirement for external review of denied claims by an independent party. For more information on your health plan's claims procedure, see your SPD.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice phone: (202)693-8664; TTY: 1(202)501-3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Need Help with Your Health Benefits?

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