AUGUST BENEFITS

Summary of Benefits and Coverage Requirement

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Federal Agencies Release Final Regulations on Summary of Benefits and Coverage Requirement Under PPACA

The Patient Protection and Affordable Care Act (PPACA) generally requires group health plans and health insurance issuers offering group health coverage to prepare and distribute to plan participants and beneficiaries a brief, standard summary of the plan's benefits and coverage. This summary is called the summary of benefits and coverage (SBC), also commonly known as the "four-page summary." On Feb. 14, 2012, the U.S. Departments of Treasury, Labor and Health and Human Services (the Departments) released final regulations and guidance relating to the SBC requirement. The regulations and guidance clarify proposed regulations that were issued in August 2011. They also ease some of the more onerous components of the requirement and grant a six-month delay in the statutory effective date (moved from March 23, 2012, to Sept. 23, 2012).

This white paper focuses on:

- The background of the SBC requirement
- The requirement's effective date
- Types of plans subject to the requirement
- The responsibility, timing and delivery of the SBC
- SBC content
- Standards for the SBC's appearance, language and distribution
- Penalties relating to noncompliance
- Frequently asked questions relating to the SBC requirement

The Background of the SBC Requirement

Under PPACA, plan administrators of group health plans (or health insurance issuers in the case of fully insured plans) must provide to participants and beneficiaries an SBC that accurately describes the benefits and coverages of each benefit package under the plan. Also, the health insurance issuer must provide an SBC to the group health plan sponsor. The SBC requirement is in addition to ERISA's summary plan description (SPD) and summary of material modification (SMM) requirements.

The purpose of the requirement is to provide individuals with a better understanding of the health coverage offered under the plan and a means for comparing various health plans and policies. To achieve this purpose, the SBC is subject to strict content, appearance, format and language requirements. Importantly, the SBC must include a uniform glossary that clearly defines plan and benefit terminology, as well as coverage examples that illustrate benefits provided under the plan or coverage for common benefits scenarios. In addition, plans and issuers must provide a notice of modification in any terms of the plan or coverage that would affect the content of the SBC. PPACA directs the Departments to develop standards and definitions to help achieve the requirement's purpose.

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On Aug. 22, 2011, the Departments published proposed regulations on the SBC requirement, as well as a companion document that proposed an SBC template (with instructions, sample language and a guide for coverage examples calculations to be used in completing the SBC template) and a uniform glossary.

On Feb. 14, 2012, the Departments published final regulations on the SBC requirement. The final regulations track the proposed regulations to an extent, but include a delayed effective date and other clarifications. The final regulations also eliminate the requirement that the SBC contain premium information. In addition to the final regulations, the Departments issued:

- A compliance guidance document
- An SBC template
- A sample completed SBC template
- Instructions for completing SBCs
- A uniform glossary of coverage and medical terms

The final regulations and these additional documents are located in the Additional Resources section of this document.

Effective Date

As enacted, the SBC requirement was meant to apply as of March 23, 2012. However, to give plans and insurers time to properly implement the provisions, the final regulations delayed the effective date until Sept. 23, 2012. This means that the requirements are applicable beginning on the first day of the open enrollment period beginning on or after Sept. 23, 2012. For participants and beneficiaries who enroll in group health plan coverage outside of open enrollment (i.e., new hires and special enrollees), the SBC must be provided on the first day of the first plan year that begins on or after Sept. 23, 2012.

Plans Subject to the Requirements

The SBC requirements apply to most group health plans, including self-insured and fully insured plans. Grandfathered plans are also subject to the requirements. Plans that are not subject to the requirements include “excepted benefits” (as defined in HIPAA), which includes stand-alone dental and vision plans and many health flexible spending accounts (FSAs) and retiree-only plans (a plan that covers less than two current employees as participants). As for health reimbursement arrangements (HRAs), since an HRA generally does not meet the definition of “excepted benefit” under HIPAA, an HRA is likely subject to the SBC requirements. If integrated with the major medical coverage, however, the HRA can be included in the SBC for the major medical plan. A stand-alone HRA will need to provide its own SBC.

As for health savings accounts (HSAs), an HSA is generally not considered a “group health plan” and therefore an HSA is not subject to the SBC requirements. Nevertheless, an SBC prepared for a high-deductible health plan (HDHP) associated with the HSA will need to mention the effect of employer contributions to the HSA, and the HSA’s effect on the HDHP’s deductible, in the appropriate spaces.

The final regulations note, however, that even exempt FSAs or HSAs may need to be referenced in an SBC for a comprehensive medical plan, as a way of explaining the plan’s deductible and other copayment features.

Plans Subject to SBC Requirement	Plans Not Subject to SBC Requirement
Self-insured major medical group health plans of any size	Stand-alone dental
Fully insured major medical group health plans of any size	Stand-alone vision
Either fully or self-insured qualifying HDHP major medical plans	HIPAA-excepted health FSAs
Either fully or self-insured major medical plans that are integrated with an HRA	Retiree-only
Stand-alone HRAs	Dependent care FSAs
	HSAs

Responsibility, Timing and Delivery of the SBC

As for responsibility and timing for providing the SBC, these requirements vary based on the circumstances of each particular plan design. For group health plan coverage, the final regulations require provision of an SBC in two different circumstances:

1. From a health insurer or group health plan to a participant or beneficiary
2. From a health insurer to a plan sponsor (which applies only in a fully insured arrangement)

SBC to Participants and Beneficiaries

With respect to the first circumstance, the plan administrator of a group health plan is generally responsible for providing the SBC to plan participants and beneficiaries for each benefit package under the plan. In the case of an insured plan, however, the insurer is equally responsible. Moreover, if an insurer provides a timely and accurate SBC, then the plan administrator is not required to do so. For more information on this, please see FAQs 1 and 2.

The SBC must be provided at the following times:

1. **Initial application or enrollment.** As part of any written application materials that are distributed for enrollment (electronic or written). If no application materials are distributed, then the SBC must be provided by the first day on which the participant (or beneficiary) is eligible to enroll in the coverage.

2. **Special enrollment.** The SBC must be provided to HIPAA special enrollees no later than 90 days from enrollment. HIPAA special enrollees may include the employee, spouse and any newly acquired dependents that enroll due to loss of eligibility for coverage, birth, adoption or placement for adoption, marriage or becoming eligible for premium assistance through a state Medicaid or Children's Health Insurance Program.

3. **Renewal.** If applicable, only for those benefit options in which the participant or beneficiary is already enrolled, the SBC must be provided no later than 30 days prior to the first day of the new policy year (for automatic renewals) or by the date the written renewal application materials are distributed to the plan sponsor (for non-automatic renewals).

4. **Upon request.** The SBC must be provided within seven business days following the request.

As for delivery of the SBC, the SBC can be provided as a stand-alone document or in combination with the SPD (so long as the SBC is prominently displayed early in the SPD's provisions, i.e., directly after the SPD table of contents, and so long as the SBC is provided in a timely manner). Importantly, though, since the SBC must be provided more often than the SPD and since the SBC must be delivered to participants and beneficiaries (whereas the SPD must only go to participants), there may be additional challenges with attaching the SBC to the SPD.

Plan administrators and insurers may provide an SBC to plan participants and beneficiaries in paper or electronic form. For participants and beneficiaries already covered under the plan, electronic delivery of the SBC must satisfy the DOL's electronic delivery rules.* For eligible participants and beneficiaries who are not yet enrolled in coverage, the SBC may be delivered electronically if the format is readily accessible, the SBC is provided in paper (and free of charge) upon request, and (in the case of an Internet posting of the SBC) the plan or issuer timely notifies the individual (either by paper or by email) of the SBC's availability on the Internet and in paper form. Finally, a single SBC can be provided to a family, except where a family member is known to live at a different address.

SBC to Plan Sponsors

With respect to the second circumstance, the health insurer (i.e., carrier) must provide an SBC to the plan sponsor of a group health plan at the following times:

1. **Initial application.** The SBC must be provided as soon as practical, but no later than seven days following receipt of an application for group health coverage from a plan sponsor.

2. **Renewal.** If the insurance carrier renews or reissues the policy, certificate or contract of insurance (i.e., for a succeeding plan year), the carrier must provide the SBC no later than 30 days prior to the first day of the new plan year (for automatic renewals) or the date the written application materials are due for non-automatic renewals.

3. Upon request. If the plan sponsor requests an SBC, the SBC must be provided within seven days.

Employers should consult with insurers and third-party administrators in preparing and distributing SBCs to ensure that their obligations and responsibilities are met. For more information on distribution requirements, see FAQs 3 and 4.

SBC Content

PPACA has strict requirements relating to the content of the SBC. According to the final regulations, the SBC must generally include the following:

1. A uniform definition of standard insurance terms and medical coverage
2. A description of the plan's coverage for each category of benefits, including cost-sharing
3. The plan's benefit exceptions, reductions and limitations
4. Information relating to renewability and continuation of coverage
5. A "coverage facts label," which includes hypothetical coverage examples to illustrate the benefits that would be provided for certain common benefit scenarios
6. Internet addresses or contact information for obtaining a list of network providers, information about any prescription drug formulary, the uniform glossary, and the plan document, insurance policy, contract or certificate of insurance
7. A statement that the SBC is only a summary, and that the plan document, insurance policy, contract or certificate of insurance should be consulted for more information about the coverage provided under the plan

With respect to the coverage facts label, the final regulations include two coverage examples: one for maternity care and one for Type 2 diabetes. The purpose of the coverage examples is to show how claims for specific benefits would be processed so that a participant can see an estimate of cost-sharing and payment. Links to the coverage examples can be found in the Additional Resources section of this document.

Finally, for coverage beginning on or after Jan. 1, 2014, the SBC must include a statement as to whether the plan provides minimum essential coverage and whether the plan pays at least 60 percent of the total cost of benefits.

SBC Appearance, Form and Language Requirements

In addition to the strict content requirements, the SBC must also meet strict requirements with respect to its appearance, form, manner and language. Specifically, the SBC must be printed in 12-point or larger font and must be limited to four double-sided pages. It must be presented in a uniform format and use terminology understandable by the average enrollee. The DOL has provided model SBCs, and plan administrators and insurers are encouraged (although not required) to use the model SBCs in meeting the requirements.

With respect to language, the SBC must be provided in a "culturally and linguistically appropriate" manner, similar to the PPACA rules for group health plan claims and appeals communications. Generally, the plan must disclose the availability of language services and provide written translation of an SBC for certain counties that have been identified by the U.S. Census Bureau as having a concentration of at least 10 percent who speak the same non-English language. A list of the 255 affected counties is included in the Additional Resources section below. The U.S. Department of Health and Human Services will make available written translations of the SBC template, sample language and uniform glossary in Spanish, Tagalog, Chinese and Navajo.

Other SBC Requirements

SBC Modifications

Under the final regulations, if the group health plan or insurer makes a material modification to the SBC outside of renewal or reissuance (for example, a midyear plan design change) that would require a change in the SBC, the plan or carrier must provide notice of the modification to enrollees no later than 60 days prior to the date the modification will take effect. The 60-day advance notice may be provided through a separate notice or through an updated SBC. This modification requirement is in addition to current ERISA rules, which generally require the provision of an SMM within 60 days after adoption of a material reduction in covered benefits (or within 210 days for other plan modifications).

However, the final SBC regulations state that in situations where a complete notice or an updated SBC is provided informing participants of the modification or change, the requirements to provide an SMM under ERISA will also be satisfied.

For more information on material modifications and SBCs, see FAQs 5 and 6.

Existing ERISA Requirements		New SBC Requirement
Summary of Material Modification (SMM)	**Summary of Material Reduction in Covered Benefits or Services**	**SBC Modifications**
• Must be provided upon any material modification to the plan and any change in the information required to be in the SPD.	• Same requirements as SMM, except that expedited requirements apply upon a material reduction in covered benefits or services.	• Must be provided when there is a material modification of plan terms or coverage that is not reflected in the most recently provided SBC.
• Must be written in plain language so that the average plan participant can understand (no model notice available)	• Must be written in plain language so that the average plan participant can understand (no model notice available)	• May be provided through a separate SMM notice or through an updated SBC.
• Must be provided within 210 days of the end of the plan year in which the modification is adopted.	• Must be provided within 60 days after the material reduction in covered benefits or services is adopted.	• Must be provided at least 60 days before the modification becomes effective.
• Any SMMs that are not yet included in the SPD must be distributed along with the SPD until a revised SPD is distributed.	• Any SMMs that are not yet included in the SPD must be distributed along with the SPD until a revised SPD is distributed.	• Complying with this SBC Modification requirement will satisfy the existing ERISA requirements.

Uniform Glossary

In addition to including a uniform glossary in the SBC itself, plans and insurers must make a uniform glossary available to participants and beneficiaries in either paper or electronic form. The uniform glossary may not be modified and must be provided upon request by a participant or beneficiary within seven business days.

Coverage Offered Outside the U.S.

For plans that provide coverage outside the U.S. (i.e., expatriate coverage), plans and insurers may offer an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the U.S., rather than distributing SBCs to plan participants and beneficiaries.

Penalties

The penalties associated with noncompliance are significant. Specifically, a group health plan or insurance carrier that willfully fails to provide the SBC to a participant or beneficiary is subject to a fine of up to $1,000 per participant or beneficiary. In addition, such plans or carriers may also need to self-report noncompliance on Form 8928 and pay an excise tax to the Internal Revenue Service of $100 per day per individual for each day that the plan fails to comply with the requirement.

Summary

Employers sponsoring group health plans will want to review this guidance and work with insurance carriers and third-party administrators to prepare the SBCs, uniform glossary and any material modification notices in compliance with the new Sept. 23, 2012, deadline. Employers will want to pay special attention to open enrollment dates and plan year openings in order to satisfy the new requirements. To assist in complying with these requirements, the Departments have provided SBC instructions, sample SBCs, a standard uniform glossary and a compliance guide (all of which can be accessed in the Additional Resources section below).

FAQs

1. Who is a participant or beneficiary for purposes of SBC distribution?

The definition of "participant" includes any employee or former employee who is or may become eligible to receive a benefit from an employee benefit plan. The definition of "beneficiary" includes a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit.

In practice, this means that employers must provide the SBC to any employee who is eligible to participate in the plan, regardless of whether that person is actually enrolled or not. As discussed above, when an employee is initially eligible to enroll in the plan, the SBC needs to be provided on the first day the employee is eligible to enroll in the plan, regardless of whether he or she actually enrolls in coverage. If the employee chooses to enroll a dependent, then that dependent is considered a beneficiary and must also receive the SBC. Further, the eligible employee must receive the SBC each year at open enrollment, even if he or she is not enrolled in coverage. Finally, an eligible employee or a covered beneficiary may request the SBC at any time and must receive it within seven business days, regardless of whether he or she is enrolled in coverage at the time of the request.

2. The insurer is distributing the SBC for our employer-sponsored group health plan. Does the employer also have to distribute the SBC?

The requirement to provide an SBC is generally satisfied as long as the SBC is provided by any entity within the time frame required and satisfies the content requirements. Therefore, if the insurer has provided the SBC in accordance with the time frames outlined above, then the employer does not also have to distribute the SBC. While this special exception does avoid unnecessary duplication of the SBC distribution requirement, employers will need to be aware of what responsibility an insurer is fulfilling and what responsibility the employer will retain.

3. Does an employer need to distribute an SBC to every dependent (beneficiary) for whom an enrolled employee provides coverage?

No. The employer may provide a single SBC to a participant and to any beneficiaries at the participant's last known address. However, if a beneficiary's last known address is different from the participant's last known address, a separate SBC must be provided to the beneficiary at the beneficiary's last known address.

Another point to consider is in situations where a beneficiary enrolls in coverage for the first time, separately from the employee's enrollment. For example, if a new spouse exercises her HIPAA special enrollment right to enroll midyear, when the employee is already enrolled, then she would need to be provided a separate SBC within 90 days of her enrollment on the plan.

4. Can the SBC be emailed to employees or posted on an employer's intranet?

An employer could provide the SBC to participants via a work email address if the participant has email access at their regular place of work on a daily basis as part of their work duties. The email should include a statement indicating the significance of the document, that a paper version of the notice is available and how to obtain one, and that the participant is responsible for providing a copy of the notice to their dependents (beneficiaries) who are covered under the group health plan. Additionally, the employer should post the notice on the employer's website with a link to the notice on the website's main page.

If an employee does not have access to work email as a part of their regular work duties, the employer may still email the notice to them, but certain conditions must be met first:

- The individual must notify the employer that they have adequate electronic access, provide the employer with a valid email address and send an email to the employer consenting to the electronic notification.
- The employer must notify the individual of their right to a paper version of the notice, how to cancel their consent, how to revise an address, and any hardware/software requirements.

A hand-delivered copy is not recommended as a primary method of distribution. For those individuals who do not receive the notice electronically, first-class mail is the preferred method of delivery.

5. What constitutes a "material" modification?

Material modifications include, among other things, amendment provisions that establish new benefits, take away existing benefits, narrow or expand the circumstances under which benefits are paid, and terminate the plan entirely. If the amendment changes the information required to be disclosed in an SPD, an SMM should be distributed. One court found that an amendment to an insured plan to exclude high-dose chemotherapy for breast cancer has been found to be material. Another court found that a modification of a plan to create two classifications of retirees for purposes of premium contributions was a material modification.

Not all amendments to a plan are material modifications. For example, some courts have held that an amendment that merely clarifies plan language and does not affect substantive changes is not a material modification. Also, a change in how plan administrative expenses were paid did not constitute a material modification triggering the need for an SMM, because plan language already contained provisions permitting the change.

6. What is the difference between a material modification and a material reduction in group health plan covered services or benefits?

A material modification can include a material reduction in group health plan covered services or benefits. Whether a modification to the plan or change in the information is required in the SPD will depend on whether the change would be considered by the average plan participant to be an important reduction in covered services or benefits, which constitutes a "material reduction." However, DOL final regulations provide several examples of what qualifies as a group health plan reduction in covered services or benefits. While not inclusive, these examples can be helpful when determining whether a material reduction has occurred:

- An elimination of benefits payable under the plan;
- A reduction of 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);
- An increase in premiums, deductibles, coinsurance, copayments or other amounts to be paid by a participant or beneficiary;
- A reduction in the service area covered by an HMO; and
- An imposition of new conditions or requirements (i.e., preauthorization requirements) in obtaining services or benefits under the plan.

If a plan makes a material reduction in group health plan covered services or benefits that is not discussed as part of the SBC requirement, participants and beneficiaries must be notified of the change within 60 days after the material reduction in covered benefits or services is adopted. Conversely, if a plan makes a material reduction in group health plan covered services or benefits that is discussed as part of the SBC requirement, if the plan provides a separate SMM notice or an updated SBC at least 60 days before the change is effective, then the plan has complied with both new and existing ERISA requirements.

Additional Resources

SBC Final Regulations:
http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=25818&AgencyId=8&DocumentType=2

SBC Instructions for Group Coverage:
www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf

SBC Template:
http://www.dol.gov/ebsa/pdf/correctedsbctemplate.pdf

SBC Guidance for Compliance:
http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=25819&AgencyId=8&DocumentType=2

Sample Completed SBC:
http://www.dol.gov/ebsa/pdf/CorrectedSampleCompletedSBC.pdf

Sample Language for SBC "Why This Matters" Section (for "Yes" Answers):
www.dol.gov/ebsa/pdf/SBCYesAnswers.pdf

Sample Language for SBC "Why This Matters" Section (for "No" Answers):
www.dol.gov/ebsa/pdf/SBCNoAnswers.pdf

Uniform Glossary:
www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf

Coverage Example (Diabetes Narrative):
http://cciio.cms.gov/resources/files/Files2/02102012/diabetes-narrative-2-7-12.pdf

Coverage Example (Diabetes Scenario):
http://cciio.cms.gov/resources/files/diabetes-scenario.pdf

Coverage Example (Maternity Narrative):
http://cciio.cms.gov/resources/files/Files2/02102012/maternity-narrative-2-7-12.pdf

Coverage Example (Maternity Scenario):
http://cciio.cms.gov/resources/files/Files2/02102012/accessible-maternity-scenario-2-7-12.pdf

Table of County Populations for "Culturally and Linguistically Appropriate" Requirement (Pages 14-17):
www.gpo.gov/fdsys/pkg/FR-2011-06-24/pdf/2011-15890.pdf

*Very generally speaking, those rules are satisfied if the plan participant either has electronic access as an integral part of their job or has agreed to receive such documents via email.