Overview of the New “Summary of Benefits and Coverage” Disclosure Requirements

In general, the new summary of benefits and coverage (SBC) disclosure rules for group health plans will go into effect as follows --

- **For individuals who enroll during open enrollment** -- as of the first annual enrollment period that begins after September 22, 2012 (which, for a calendar year plan, will presumably be the open enrollment period for the 2013 plan year); and

- **For individuals who enroll outside of open enrollment** -- as of the first plan year that begins after September 22, 2012 (which, for a calendar year plan, will be the 2013 plan year).

Set out below is an overview (in Q&A format) of the new SBC requirements.

**A. Who must provide an SBC?**

- In general, the plan administrator (and, for any insured benefits, the insurer) must provide the required SBC for each “benefit package” under a group health plan.

  - In general, a benefit package includes any coverage option offered under a plan (e.g., PPO, EPO or HMO)
    - While this will also include health reimbursement accounts (HRAs) as well, note that if the HRA is integrated with a health coverage option, a separate SBC will not be required for the HRA. Instead, all that must be done is mention the HRA in the SBC for the coverage option.

  - Keep in mind, though, that this requirement generally does not apply to --
    - dental and vision plans (for which separate premiums are charged),
    - most healthcare flexible spending account programs,
    - health savings accounts (HSAs), and
    - any separate retiree health plan (that is otherwise exempt from healthcare reform).
In addition, for an insured plan that has separate ("carve-out") arrangements with different vendors (e.g., pharmacy benefit manager), responsibility for completing/sending (or providing needed information for) the SBC can be delegated to the other vendor in certain circumstances pursuant to a binding contractual arrangement.

B. Who must be given an SBC?

- In general, both participants and eligible beneficiaries must be given an SBC. This includes both current and former employees who are either covered or eligible for coverage (including COBRA beneficiaries), as well as their eligible spouses/domestic partners and children. Note, though, that the provision of a SBC to a participant will satisfy the delivery requirement for his/her beneficiaries (unless the beneficiary's last known address is different, in which case the SBC must be separately delivered to the beneficiary).

C. When must an SBC be provided?

- An SBC must be provided as follows:
  - For annual enrollment -- with the annual enrollment package (unless enrollment is automatic, in which case, the SBC must be provided no less than 30 days before the beginning of the new plan year). Note, though, that where a group health plan offers more than one "benefit package", the plan need only provide an SBC for the package in which the participant or beneficiary is enrolled at the time of open enrollment.
  - For newly eligible employees/dependents -- with the enrollment package (or, if no enrollment package is provided, by the first day on which the individual is eligible to enroll).
  - For HIPAA-required mid-year enrollments -- within 90 days of the date the individual becomes covered under the plan. Note that this would include the mid-year enrollment of a new spouse or new child (whether by birth, adoption or placement for adoption). It also includes individuals who lose other group health coverage due to the following events (and meet certain other requirements): (i) the exhaustion of COBRA continuation coverage, (ii) legal separation or divorce, (iii) a spouse’s or parent’s death, (iv) loss of dependent status, (v) termination of employment or reduction in hours, (vi) an employer’s termination
of other coverage (or contributions for that coverage), (vii) reaching the other plan’s maximum lifetime limits, (viii) moving outside the plan’s coverage area, or (ix) loss of State children’s health insurance program (SCHIP) coverage or becoming eligible for a subsidy to help pay for employer-sponsored coverage.

- Upon request by a participant or beneficiary -- must be sent within 7 business days following receipt of the request.

D. What is required if a material change is made to the plan that affects SBC content?

- In general, in the case of a “material modification” that has an impact on SBC content, a summary (or an updated SBC) must be provided to affected enrollees no less than 60 days before the change becomes effective.

- For this purpose, a “material modification” is generally any mid-year benefit or coverage change (be it a reduction or an enhancement) that an average participant could, either alone or in combination with other changes, consider to be important.

  Note, though, that if the material modification will not go into effect until the next plan year, a separate summary is not required. Instead, the SBC provided at open enrollment should include the change.

E. Can an SBC be delivered electronically?

- In general, an SBC must be delivered in the same manner as a summary plan description (SPD) under the applicable ERISA rules. Thus, electronic delivery is generally permitted only to the extent that it will result in actual delivery.

  Note, though, that the Department of Labor (DOL) has announced that it is permissible to provide the SBC electronically as part of an online enrollment process (provided participants also have the option to request a paper copy).

- In addition, in the case of eligible individuals who are not enrolled, a SBC may be made available electronically (e.g., by posting on an intranet site) where the following requirements are met --

  1. the format is “readily accessible”,

  2. a paper copy of the SBC will be provided free of charge upon request, and
3. where the SBC is posted, the individual is timely notified (either by mail or e-mail) where the documents can accessed on-line and how a paper copy can be requested (Note that DOL model language for this is available at http://www.dol.gov/ebsa/faqs/faq-aca8.html (Q12)).

F. What is the required form/content for an SBC?

- In general, an SBC may be provided either as a stand-alone document or with other plan materials (as long as the required SBC information is kept intact and prominently displayed at the beginning of the other materials).

- In regard to format, the SBC must be no more than four double-sided pages (total of 8 pages) and use at least a 12-point font.
  
  Note, though, that government officials have informally stated that more pages can be used (where an administrator otherwise used best efforts to comply with the page limits).

- The SBC must be understandable to the average enrollee and “culturally and linguistically appropriate.” Thus, where eligible individuals reside in a county where 10 percent or more of the residents are only literate in a particular foreign language (as determined by the census bureau, of which there are currently 255 counties), the following is required:
  
  - the SBC must include a statement in the applicable non-English language that an SBC is available in that language,
  
  - a foreign language version must be provided upon request (and any subsequent plan updates must be provided in that language), and
  
  - if the plan has a customer assistance process (such as a telephone hotline), assistance in that language must be available.

Note that written translations of the SBC template and uniform glossary in Spanish, Chinese and Tagalog are available at Health and Human Services.

- An SBC must generally contain the following --

  - uniform definitions of standard insurance and medical terms (the aim of which is to enable consumers to compare health coverage options and understand the terms/limits of their coverage);

  - a description of coverage for each option;

  - coverage exceptions, reductions and limitations;
- cost-sharing provisions (*i.e.*, deductible, copayment and coinsurance);
- renewability and continuation coverage provisions;
- coverage examples for common benefit scenarios (such as pregnancy and serious/chronic conditions -- e.g., diabetes), up to a maximum of six;
- beginning January 1, 2014, statement about whether the coverage is “minimum essential coverage” and whether the coverage meets applicable minimum value requirements;
- a statement advising that the SBC is only a summary and that the plan document, policy, or insurance certificate should be consulted for governing plan provisions;
- contact information for questions and/or obtaining a copy of the plan document or insurance policy;
- for a plan with more than one provider network, an internet address or other contact information for obtaining the network provider list;
- for a plan that has a prescription drug formulary, an internet address or other contact information for requesting drug coverage information; and
- an internet address for obtaining the uniform glossary and contact information for requesting a paper copy of the glossary.

*Note* that the government has developed a uniform glossary for this purpose (see below). The glossary must be provided to participants and beneficiaries upon request (within 7 business days).

- **DOL** has issued additional guidance that clarifies that it is generally permissible to combine different coverage tiers, cost-sharing tiers (e.g., deductibles & co-pays) and add-on arrangements that impact major medical coverage (e.g., health FSA, HRA, HSA & wellness programs) into one SBC.

- However, it is not permissible to simply cross-reference the plan’s summary plan description as a substitute for any required SBC content (although it is okay to otherwise cite the SPD).
Lastly, an SBC need not describe any coverage provided outside of the United States. Instead, all that is required is that an internet address (or other similar contact information) for obtaining information on such coverage be provided.

In addition, DOL has announced that it will not take any enforcement action for a failure to provide a SBC for expatriate coverage for the first year that the SBC requirements apply (generally 2013).

The government has developed the following sample blank/completed SBCs, instructions and other guidance:

2. Completed SBC (www.dol.gov/ebsa/pdf/CorrectedSampleCompletedSBC.pdf)
3. SBC Instructions (www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf)
4. Explanation of Why This Matters language for "Yes" Answers (www.dol.gov/ebsa/pdf/SBCYesAnswers.pdf)
5. Explanation of Why This Matters language for "No" Answers (www.dol.gov/ebsa/pdf/SBCNoAnswers.pdf)
6. HHS Information for Simulating Coverage Examples (http://cciio.cms.gov/resources/other/index.html#sbcug)

G. What are the potential penalties for non-compliance?

The health care reform law provides for a penalty of up to $1,000 per day for each willful failure to provide the required disclosure (which is to be assessed on a per participant/beneficiary basis)

Note, though, that the DOL has established a good faith compliance standard for the first year that SBCs are required, as it has announced that it will not impose penalties for any plan that is “working diligently and in good faith” to provide the required SBC.

In addition, there is a separate $100 per day excise tax (which must be self-reported on IRS Form 8928) for each individual for which a group health plan fails to comply with the disclosure requirement.

However, the IRS has the authority to reduce or waive the tax where the failure is due to “reasonable cause.”