SUMMARY OF BENEFITS AND COVERAGE (SBC)
-EXPLANATION-

Introduction

Health care reform expands ERISA's disclosure requirements by requiring that a "summary of benefits and coverage" be provided to applicants and enrollees before enrollment or re-enrollment. The summary (referred to as the SBC) must accurately describe the "benefits and coverage under the applicable plan or coverage." The requirement applies beginning with the first open enrollment period beginning on or after September 23, 2012 for participants and beneficiaries enrolling or re-enrolling through open enrollment. For individuals enrolling other than through open enrollment (e.g., newly eligible individuals or special enrollees), the requirement applies beginning on the first day of the first plan year that begins on or after September 23, 2012. For calendar-year plans, this means that SBCs will first be required during open enrollment in 2012 for the 2013 plan year. But for some non-calendar-year plans, the SBC rules may first apply to newly eligible individuals and special enrollees.

The SBC requirement applies to so-called "grandfathered" health plans under health care reform—that is, it is not one of the requirements from which those existing group health plans and health coverage were excused.

The various governmental agencies released a template and instructions which contained sample language for completing the template and provided a uniform glossary of terms used for health coverage. The SBC template and related materials are available on the websites of the DOL and HHS. Included among the materials are:

- SBC template (available in modifiable format in MS Word)
- Sample completed SBC
- Instructions
- Why This Matters language (to be used when completing this column on the first page of the SBC template)
- Coverage examples (includes information necessary to perform the coverage example calculations)
- Uniform glossary of coverage and medical terms

*See http://www.dol.gov/ebsa/healthreform and
http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html

Plans and insurers are instructed to use the full SBC template, but to the extent a plan's terms cannot reasonably be described in a manner consistent with the template and instructions, the plan or insurer must accurately describe the relevant terms while using "best efforts" to do so in a manner as consistent as reasonably possible with the instructions and template format.

Which Plans Are Required to Provide the SBC?

The SBC requirement applies to group health plans (both insured and self-insured) and insurers but not to certain "excepted benefits." The SBC template is intended to be used by all types of plans or coverage designs.

The SBC requirements do not apply to excepted benefits (which include many health FSAs and certain HRAs). Information about health FSAs and HRAs that are not excepted benefits, but are integrated with other major medical coverage, can be included in the appropriate spaces on the major medical SBC for deductibles, co-payments, co-insurance, and benefits otherwise not

covered by the major medical coverage. But stand-alone health FSAs and HRAs that are not excepted benefits must satisfy the SBC requirements independently. Since HSAs are generally not group health plans, they are generally not subject to the SBC requirements.

Who Must Provide the SBC?

The SBC must be provided by plan administrators (for self-insured health plans) and plan administrators or insurers (for insured health plans). So, if the group health plan is self-insured, the obligation to provide an SBC lies solely with the plan administrator (usually the plan sponsor unless another entity is named as such in the plan documents). If the plan is fully insured, the obligation to timely provide an SBC lies both with the plan administrator and the insurer.

Who Must Be Furnished the SBC?

The SBC must be distributed to all applicants (at the time of application), policyholders (at issuance of the policy), and enrollees (at initial enrollment and annual enrollment). The plan (including the plan administrator) and the insurer must automatically provide an SBC to participants and beneficiaries with respect to each "benefit package" offered for which the participant or beneficiary is eligible. Information can be combined for different coverage tiers (self-only, employee-plus one coverage and family coverage) in one SBC, provided the appearance is understandable.

When Must the SBC Be Distributed?

Group health plans and insurers are required to provide an SBC to a participant or beneficiary with respect to each "benefit package" offered for which the participant or beneficiary is eligible. The SBC must be distributed at various times, as outlined below.

At Open Enrollment (Renewal): The SBC must be included with open enrollment materials. If the plan or insurer requires participants or beneficiaries to renew in order to maintain coverage for a succeeding plan year, a new SBC must be provided no later than the date the renewal materials are distributed. If renewal is automatic, the SBC must be furnished no later than 30 days prior to the first day of the new plan year. For insured plans, if the new policy has not yet been issued 30 days prior to the beginning of the plan year, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the policy.

In an effort to reduce unnecessary duplication with respect to group health plans that offer multiple benefit packages, in connection with renewal, the plan or insurer only need to automatically provide a new SBC with respect to the benefit package in which a participant or beneficiary is enrolled. SBCs are not required to be provided automatically with respect to benefit packages in which the participant or beneficiary is not enrolled. However, if a participant or beneficiary requests an SBC with respect to another benefit package for which the participant or beneficiary is eligible, the SBC must be provided as soon as practicable, but in no event later than seven business days following the request.

At Initial Enrollment: The SBC for each benefit package offered for which the participant or beneficiary is eligible must be provided as part of any written application materials that are distributed by the plan or insurer for enrollment. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage for the participant and any beneficiaries. In the unlikely event that there is any change to the information required to be in the SBC before the first day of coverage (e.g., prior to the end of the plan's waiting period), the plan or insurer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

At Special Enrollment: The plan or insurer must also provide the SBC to special enrollees (employees and dependents with the right to enroll in coverage midyear upon specified circumstances) within 90 days after enrollment pursuant to a special enrollment right, which is the timeframe for providing SPDs.

Upon Request: The plan or insurer must provide the SBC to a participant or beneficiary upon request, as soon as practicable, but in no event later than seven business days following the request.

How are the SBCs Distributed to Participants and Beneficiaries?

An SBC provided by a plan or insurer to a participant or beneficiary may be provided in paper form. Alternatively, for plans and insurers subject to ERISA (including plans sponsored by private-sector employers) or the Code (including plans subject to ERISA and church plans not subject to ERISA), the SBC may be provided electronically to participants and beneficiaries covered under the plan if the requirements of the DOL's electronic disclosure safe harbor are met.

For participants and beneficiaries who are eligible but not enrolled, the SBC may be provided electronically if the format is readily accessible and a paper form is provided free of charge upon request. For these participants and beneficiaries only, the SBC may be provided via Internet posting if the individuals are notified in paper form (such as a postcard) or via email that the documents are available on the Internet. The postcard or email must provide the Internet address and indicate that the documents are available in paper form upon request.

How should the SBC Appear?

The SBC be presented in a uniform format, utilize terminology understandable by the average plan participant, not exceed four pages in length, and not include print smaller than 12-point font.

The SBC is designed to be provided in the form authorized by the agencies and completed in accordance with the instructions and guidance. Plans and insurers may provide the SBC either in color or grayscale. Group health plan SBCs may be provided either on a stand-alone basis or in combination with other summary materials (such as the SPD) if certain requirements are met. If the SBC is provided in combination with other materials, it must remain intact and must be prominently displayed at the beginning of the materials (such as immediately after a table of contents), and the timing requirements for providing the SBC must still be satisfied.

What are the Language Requirements for the SBC?

The SBC must be presented in a “culturally and linguistically appropriate manner.” To satisfy this requirement, a plan or insurer should follow the rules for providing appeals notices in a culturally and linguistically appropriate manner under PHSA § 2719 and its implementing regulations. In general, those rules provide that for materials sent to an address in specified counties of the United States, plans and insurers must provide oral language services in the applicable non-English language, include a one-sentence statement in the English versions of the SBC—prominently displayed in the non-English language—clearly indicating how to access the language services, and must provide written translations of the SBC upon request in the applicable non-English languages. The counties in which this must be done are those in which at least 10% of the population residing in the county is literate only in the same non-English language. This determination is based on U.S. Census data. In order to assist with compliance with this language requirement, HHS will provide written translations of the SBC template,

sample language, and uniform glossary in the four applicable languages (Spanish, Tagalog, Chinese, and Navajo) and may also make these materials available in other languages.

What are the Content Requirements for the SBC?

The SBC must include the following information:

- Uniform definitions of standard insurance and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage.
- A description of the coverage, including cost-sharing, for each category of benefits identified by the agencies.
- Exceptions, reductions, and limitations on coverage.
- Cost-sharing provisions, including deductible, co-insurance, and co-payment obligations.
- Renewability and continuation of coverage provisions.
- A "coverage facts label"—called "coverage examples" in the regulations—illustrating common benefits scenarios (e.g., pregnancy, serious or chronic medical conditions) and related cost-sharing based on recognized clinical practice guidelines.
- With respect to coverage beginning on or after January 1, 2014, a statement of whether the plan or coverage provides "minimum essential coverage", and whether the plan's share of the total allowed cost of benefits provided under the plan meets applicable requirements.
- A statement that the SBC is only a summary and that the plan (or policy or certificate) should be consulted to determine the governing contractual provisions.
- The telephone number to call for additional questions and to obtain a copy of the plan document, insurance policy, or group certificate of coverage (or individual coverage policy), and the Internet web address where the materials are available.
- For plans and insurers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of the network providers.
- For plans and insurers that maintain a prescription drug formulary, an Internet address where an individual may find more information about the prescription drug coverage under the plan.
- An Internet address for obtaining the uniform glossary and a contact phone number to obtain a paper copy of the glossary, and a disclosure that paper copies are available.

The coverage examples component of the SBC (referred to as the "coverage facts label" above) is intended to estimate what proportion of expenses under an illustrative benefits scenario might be covered by a given plan to allow participants and beneficiaries to use this information to compare their share of the costs of care under different plan options to make an informed enrollment decision. A benefits scenario is a hypothetical situation consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines. A benefits scenario should include the information needed to simulate how claims would be processed under the scenario to generate an estimate of cost-sharing which a participant or a beneficiary could expect to pay under the benefit package.

When must a Notice of Material Modification to the SBC be provided?

A group health plan or insurer must provide notice of a material modification if it makes a material modification in any of the terms of the plan that is not reflected in the most recently provided SBC.

Only material modifications that would affect the content required in the SBC required would require plans and insurers to provide this notice. In these circumstances, the notice must be provided no later than 60 days prior to the date on which such change will become effective, if it is not reflected in the most recent SBC provided and occurs other than in connection with a renewal (i.e., mid-plan year). The notice may be provided in paper or electronic form, in accordance with the requirements discussed above for providing the SBC.

This requirement for an advance notification could be satisfied either by a separate notice describing the material modification or by providing an updated SBC reflecting the modification.

What are the Consequences of Failing to Provide the SBC?

A penalty of up to $1,000 per failure can be assessed on plan administrators and insurers (for insured health plans) and plan administrators (for self-insured health plans) that “willfully fail” to timely provide the SBC. A failure with respect to each participant or beneficiary constitutes a separate offense. The fine cannot be paid from plan or trust assets.

No penalties will be imposed during the first year on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations.