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Summary of Benefits and Coverage

The Patient Protection and Affordable Care Act (PPACA) requires health plans and health insurance issuers to provide a **summary of benefits and coverage** (SBC) to applicants and enrollees. Both non-grandfathered and grandfathered plans will need to provide the SBC.

The SBC is a concise document providing simple and consistent information about health plan benefits and coverage. It must be provided free of charge. Its purpose is to help health plan consumers better understand the coverage they have and to help them make easy comparisons of different options when shopping for new coverage.

On Aug. 22, 2011, the Departments of Health and Human Services (HHS), Labor and Treasury (Departments) issued proposed regulations for the SBC. On **Feb. 9, 2012**, the Departments announced the release of **final SBC regulations**.

The final regulations include guidance on:

- The compliance deadline for plans and issuers to begin providing the SBC;
- The requirements for providing the SBC, including who must provide it and when it must be delivered; and
- The requirements for preparing the SBC, including its content, appearance and language.

The Departments also announced the availability of a **template** for the SBC and additional instructional guidance and sample language for completing the template, as well as the **uniform glossary** for the disclosure.

This Seubert & Associates Legislative Brief summarizes PPACA's standards for the SBC, including the final guidance provided by the Departments.

COMPLIANCE DEADLINE

The health care reform law originally required plans and issuers to start providing the SBC by March 23, 2012. However, in November 2011, the SBC compliance deadline was delayed pending the release of final SBC guidance.

The final SBC regulations provide that plans and issuers must start providing the SBC as follows:

- Issuers must provide the SBC to health plans effective **Sept. 23, 2012**.
- Plans and issuers must provide the SBC to participants and beneficiaries who enroll or re-enroll during an open enrollment period beginning with the first day of the **first open enrollment period** that begins on or after **Sept. 23, 2012**.
- For participants who enroll in coverage other than through an open enrollment period (for example, newly eligible individuals and special enrollees), plans and issuers must provide the SBC beginning on the first day of the **first plan year** that begins on or after **Sept. 23, 2012**.

PROVIDING THE SBC

Timing Requirements

For group health plans, the final regulations outline two different scenarios under which the SBC must be provided: (1) by a group health insurance issuer to a group health plan; and (2) by the issuer or plan to participants and beneficiaries.

A **health insurance issuer** must provide an SBC to a **group health plan** (or the plan's sponsor):

- Upon application for health coverage;
- By the first day of coverage, if there was any change in the information required to be in the SBC that was provided upon application and before the first day of coverage;
- When the issuer renews or reissues the policy; and
- Upon request.

A **health insurance issuer or health plan** must provide an SBC to **participants and beneficiaries** with respect to each benefit package for which the participant or beneficiary is eligible. The SBC must be provided:

- As part of any written application materials that are distributed by the plan or issuer for enrollment;
- If the plan or issuer does not distribute written application materials for enrollment, no later than the first date that the participant is eligible to enroll in coverage;
- By the first day of coverage, if there was any change to the information required to be in the SBC that was provided upon application and before the first day of coverage;
- To special enrollees, no later than the deadline for providing the summary plan description (SPD) (that is, within 90 days of enrollment);
- Upon renewal, if participants and beneficiaries must renew in order to maintain coverage; and
- Upon request (the uniform glossary must also be provided upon request).

SBCs that are provided upon application (by issuers) or upon request (by either plans or issuers) must be provided as soon as practicable, but no later than seven days after receipt of the application or request.

For providing the SBC at renewal time, if a written application is required for renewal, the SBC must be provided no later than when the application materials are distributed. If renewal is automatic, the SBC must be provided no later than **30 days** before the beginning of the new plan year.

However, an exception applies if an insured plan's policy, certificate or contract of insurance has not been issued or renewed before this 30-day period. In this case, the SBC must be provided as soon as practicable, but not later than seven days after the issuance of the new policy, certificate or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

Special Rules to Avoid Duplication

The final regulations contain three special rules to streamline the provision of the SBC and avoid unnecessary duplication.

First, if either the plan or issuer provides the SBC to a participant or beneficiary in accordance with the timing and content requirements, both will have satisfied their SBC obligations. Thus, a fully-insured plan will satisfy the requirement to provide an SBC to an individual if the issuer provides a timely and complete SBC to the individual.

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Second, a single SBC may be provided to a family, unless any beneficiaries are known to reside at a different address. Due to this rule, plans and issuers will be required to provide separate SBCs to beneficiaries only in limited circumstances.

Third, for group health plans with multiple benefit packages, the plan or issuer is required to automatically provide a new SBC at renewal only with respect to the benefit package in which a participant or beneficiary is enrolled. SBCs for other benefit package options do not have to be provided automatically at renewal, but must be provided upon request.

Exceptions for Certain Types of Plans, Policies or Benefits

The SBC requirement applies to both group health plans and health insurance issuers. In the preamble to the final regulations, the Departments state that an SBC does not need to be provided for plans, policies or benefit packages that constitute "excepted benefits" under HIPAA. Thus, for example, the SBC requirement does not apply to stand-alone dental or vision plans or health flexible spending accounts (FSAs) that qualify as excepted benefits.

If a health FSA does not meet the criteria for an excepted benefit, and it is integrated with other major medical coverage, the SBC should be prepared for the other major medical coverage and the effects of the health FSA can be included in the appropriate spaces on the SBC for deductibles, copayments, coinsurance and benefits otherwise not covered by the major medical coverage. A stand-alone FSA that is not an excepted benefit must satisfy the SBC requirements independently. A similar rule applies for health reimbursement arrangements (HRAs).

Health savings accounts (HSAs) are not group health plans and, thus, are not subject to the SBC requirement. However, the SBC for a high deductible health plan (HDHP) associated with the HSA can mention the effects of employer contributions to HSAs in the appropriate spaces on the SBC for deductibles, copayments, coinsurance and benefits not otherwise covered by the HDHP.

Effect on Other Documents

The SBC does not replace any required disclosure documents for group health plan coverage, such as the summary plan description (SPD). Rather, it adds to the list of required disclosures. However, the SBC can be provided as either a stand-alone document, or it can be provided with other summary materials (for example, the SPD). To be provided with other summary materials, the SBC information must be intact and prominently displayed at the beginning of the materials (for example, immediately after the SPD's table of contents) and provided in accordance with the SBC timing requirements.

Method of Delivery

The SBC may be provided in either paper or electronic form (such as by e-mail or an Internet posting). However, the final regulations place restrictions on the electronic delivery of the SBC.

For SBCs provided by an issuer to a health plan, the SBC may be provided electronically if:

- The format is readily accessible by the plan or its sponsor;
- The SBC is provided in paper form free of charge upon request; and
- If the electronic form is an Internet posting, the issuer timely advises the plan in paper form or e-mail that the documents are available on the Internet and provides the Internet address.

For SBCs provided to participants and beneficiaries, the SBC may be delivered electronically to participants and beneficiaries who are already covered under the group health plan if the Department of Labor's (DOL) regulations on electronic disclosure are satisfied.

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For participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if:

- The format is readily accessible;
- The SBC is provided in paper form free of charge upon request; and
- If the electronic form is an Internet posting, the plan or issuer timely notifies the individual in paper form (such as a postcard) or e-mail that the documents are available on the Internet, provides the Internet address and notifies the individual that the documents are available in paper form upon request.

PREPARING THE SBC

The SBC is to be provided in a standardized format to help provide clear, consistent and comparable information about health plan coverage and benefits. As mentioned above, the Departments have provided a **template** and a **uniform glossary** for this purpose. The Departments intend to update the template and uniform glossary in future years to incorporate health care reform changes that become effective in later years.

Group health plans and issuers are required to use the full template to satisfy the SBC requirement. To the extent a plan's terms cannot reasonably be described in a manner consistent with the template and its instructions, the plan or issuer must make its best effort to accurately describe the relevant plan terms in a way that is as consistent with the instructions and template format as is reasonably possible.

On June 26, 2012, HHS issued a memorandum with a list of information links to help with completing the SBC. The memorandum is available at: http://cciio.cms.gov/resources/files/data-team-sbc-links-memo.pdf.

Appearance

The SBC must be presented in a uniform format and must use terminology understandable by the average plan enrollee. The SBC must be relatively short; it cannot be longer than four pages. The Departments interpreted the four-page limitation as **four double-sided pages**. The SBC cannot include print smaller than **12-point font**. The SBC template may be provided in color or black and white.

Required Content

PPACA provides that SBCs must contain the following provisions:

- Uniform definitions of standard insurance and medical terms;
- A description of coverage, including cost-sharing for specified categories benefits;
- Exceptions, reductions and limitations on coverage;
- Cost-sharing provisions, including deductible, coinsurance and copayment obligations;
- Renewability and continuation of coverage provisions;
- Specified coverage examples that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions);
- A statement that the outline is a summary of the policy and that the coverage document itself should be consulted for contractual provisions;
- A contact number for consumers and a web address where a copy of the actual coverage policy or certificate of coverage can be reviewed and obtained;

- For plans and issuers with one or more provider networks, an Internet address (or similar contact information) for obtaining a list of the network providers;
- For plans and issuers with a prescription drug formulary, an Internet address (or similar contact information) for obtaining information about the prescription drug coverage; and
- An Internet address for obtaining the uniform glossary, a contact phone number to obtain a paper copy of the uniform glossary and a disclosure that paper copies are available.

The SBC is not required to include premium or cost of coverage information.

Instead of summarizing coverage for items and services provided outside the United States, a plan or issuer may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States.

Beginning in 2014, the SBC must include a statement of whether the plan provides minimum essential coverage and ensures that the plan's share of total allowed costs meets applicable requirements.

Language

PPACA requires the SBC to be presented in a culturally and linguistically appropriate manner, and use terminology that average enrollees can understand. The final regulations require plans and issuers to provide the SBC in a culturally and linguistically appropriate manner when 10 percent or more of the population residing in the individual's county are literate only in the same non-English language.

To help plans and issuers meet this requirement, HHS intends to provide written translations of the SBC template, sample language and uniform glossary in Spanish, Tagalog, Chinese and Navajo. This information should be available in the future through http://cciio.cms.gov.

UNIFORM GLOSSARY

Plans and issuers must also provide participants and beneficiaries a uniform glossary of health-coverage-related terms and medical terms. The terms included in the uniform glossary are specified by the Departments and are intended to allow individuals and employers to compare and understand the terms of coverage and medical benefits, including any exceptions to those benefits.

The uniform glossary must be provided in the format specified by the Departments. It must be presented in a uniform format and use terminology understandable by the average plan enrollee. Plans and issuers must make the uniform glossary available upon request, within seven business days after receipt of the request. The uniform glossary may be provided in either paper or electronic form, as requested.

The glossary also will be publicly available at www.HealthCare.gov, www.cciio.cms.gov and www.dol.gov/ebsa/healthreform.

MODIFICATIONS

Plans and issuers are required to give at least 60 days advance notice of any material modification in plan terms or coverage that are not reflected in the most recent SBC. This notice requirement is limited to material modifications that do not occur in connection with a renewal or reissuance of coverage.

According to the regulations, a "material modification" includes: (1) an enhancement of covered benefits or services, such as coverage of previously excluded benefits or reduced cost-sharing; (2) a material reduction in covered services or benefits, such as through increased premiums or cost-sharing; or (3) more stringent requirements for receipt of benefits, such as a new referral requirement.

The material modification notice can be provided in a separate document describing the material modification or through an updated SBC.

PENALTIES

PPACA establishes a penalty of up to $1,000 for each willful failure to provide the SBC. Failing to provide the SBC may also trigger an excise tax of $100 per day per individual for each day of noncompliance.

MORE INFORMATION

More information on the SBC, including the final template (with instructions, sample language and a guide for coverage examples calculations) and the uniform glossary, is available at: http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.

The final SBC regulations are available at: www.regulations.gov/#!documentDetail;D=HHS_FRDOC_0001-0442.

FAQs on the SBC are available at: http://www.dol.gov/ebsa/healthreform/ (Part XIII and IX).