# FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART VIII)

**March 19, 2012**

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the summary of benefits and coverage (SBC) provisions of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments). Like previously issued FAQs (available at http://www.dol.gov/ebsa/healthreform/ and http://cciio.cms.gov/resources/factsheets/), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

## Summary of Benefits and Coverage (SBC)

On February 14, 2012, the Departments published the final rules regarding the SBC.[1] These FAQs aim to answer some of the questions that have been raised to date. We intend to release additional FAQs. The Administration is committed to promoting operational efficiencies and clarifying the final regulations to ensure successful implementation.

### Q1: When must plans and issuers begin providing the SBC?

For group health plan coverage, the regulations provide that, for disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including late enrollees and re-enrollees), the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012.

For disclosures from issuers to group health plans, and with respect to individual market coverage, the SBC must be provided beginning September 23, 2012.

### Q2: What is the Departments' basic approach to implementation of the SBC requirement during the first year of applicability?

The Departments' basic approach to ACA implementation, as stated in a previous FAQ (see http://www.dol.gov/ebsa/faqs/faq-aca.html), is: "[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law

[1] See 26 CFR 54.9815-2715, 29 CFR 2590.715-2715, and 45 CFR 147.200, published February 14, 2012 at 77 FR 8668.

and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices."

In addition to the general approach to implementation, in the instructions for completing the SBC, we stated: "To the extent a plan's terms do not reasonably correspond to these instructions, the template should be completed in a manner that is as consistent with the instructions as possible, while still accurately reflecting the plan's terms. This may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program."

Consistent with this guidance, during this first year of applicability, the Departments will not impose penalties 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. The Departments intend to work with stakeholders over time to achieve maximum uniformity for consumers and certainty for the regulated community.

**Q3: Are plans and issuers required to provide a separate SBC for each coverage tier (e.g., self-only coverage, employee-plus-one coverage, family coverage) within a benefit package?**

No, plans and issuers may combine information for different coverage tiers in one SBC, provided the appearance is understandable. In such circumstances, the coverage examples should be completed using the cost sharing (*e.g.*, deductible and out-of-pocket limits) for the self-only coverage tier (also sometimes referred to as the individual coverage tier). In addition, the coverage examples should note this assumption.

**Q4: If the participant is able to select the levels of deductible, copayments, and co-insurance for a particular benefit package, are plans and issuers required to provide a separate SBC for every possible combination that a participant may select under that benefit package?**

No, as with the response to Q-3, plans and issuers may combine information for different cost-sharing selections (such as levels of deductibles, copayments, and co-insurance) in one SBC, provided the appearance is understandable. This information can be presented in the form of options, such as deductible options and out-of-pocket maximum options. In these circumstances, the coverage examples should note the assumptions used in creating them. An example of how

to note assumptions used in creating coverage examples is provided in the Departments' sample completed SBC.[2]

**Q5: If a group health plan is insured and utilizes "carve-out arrangements" (such as pharmacy benefit managers and managed behavioral health organizations) to help manage certain benefits, who is responsible for providing the SBC with respect to the plan?**

The Departments recognize that different combinations of plans, issuers, and their service providers may have different information necessary to provide an SBC, including the coverage examples.

The Departments have determined that, until further guidance is issued, where a group health plan or group health insurance issuer has entered into a binding contractual arrangement under which another party has assumed responsibility (1) to complete the SBC, (2) to provide required information to complete a portion of the SBC, or (3) to deliver an SBC with respect to certain individuals in accordance with the final regulations, the plan or issuer generally will not be subject to any enforcement action by the Departments for failing to provide a timely or complete SBC, provided the following conditions are satisfied:

- The plan or issuer monitors performance under the contract,
- If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer has the information to correct it, it is corrected as soon as practicable, and
- If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer does not have the information to correct it, the plan or issuer communicates with participants and beneficiaries regarding the lapse and begins taking significant steps as soon as practicable to avoid future violations.

**Q6: If a plan offers participants add-ons to major medical coverage that could affect their cost sharing and other information in the SBC (such as a health flexible spending arrangement (health FSA), health reimbursement arrangement (HRA), health savings account (HSA), or wellness program), is the plan permitted to combine information for all of these add-ons and reflect them in a single SBC?**

Yes. As stated in the preamble to the final regulations and the instructions for completing the SBC template,[3] plans and issuers are permitted to combine such information in one SBC, provided the appearance is understandable. That is, the effects of such add-ons can be denoted in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. In such circumstances, the coverage examples should note the assumptions used in creating them. (The Departments' sample

[2] The Departments' sample completed SBC is available at: www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf or http://cciio.cms.gov/resources/files/Files2/02102012/sample-completed-sbcfinal.pdf.pdf.

[3] See 77 FR 8668, 8670-71 (February 14, 2012) and page 1 of Instruction Guide for Group Coverage at http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf.

completed SBC[4] provides an example of how to denote the effects of a diabetes wellness program.)

**Q7: The final regulations require the SBC to be provided in certain circumstances within 7 business days. Does that mean the plan or issuer has 7 business days to send the SBC, or that the SBC must be received within 7 business days?**

In the context of the final regulations, the term "provided" means sent. Accordingly, the SBC is timely if sent out within 7 business days, even if it is not received until after that period.

**Q8: Are plans and issuers required to provide SBCs to individuals who are COBRA qualified beneficiaries?**

Yes. While a qualifying event does not, itself, trigger an SBC, during an open enrollment period, any COBRA qualified beneficiary who is receiving COBRA coverage must be given the same rights to elect different coverage as are provided to similarly situated non-COBRA beneficiaries. See 26 CFR 54.4980B-5, Q&A-4(c) (requirement to provide election) and 54.4980B-3, Q&A-3 (definition of similarly situated non-COBRA beneficiary). In this situation, a COBRA qualified beneficiary who has elected coverage has the same rights to receive an SBC as a similarly situated non-COBRA beneficiary. There are also limited situations in which a COBRA qualified beneficiary may need to be offered different coverage at the time of the qualifying event than the coverage he or she was receiving before the qualifying event and this may trigger the right to an SBC. See 26 CFR 54.4980B-5, Q&A-4(b).

**Q9: What circumstances will trigger the requirement to provide an SBC to a participant or beneficiary in a group health plan? In particular, how do the terms "application" and "renewal" apply to a self-insured plan?**

The final regulations require that the SBC be provided in several instances:

- Upon application. If a plan (including a self-insured group health plan) or an issuer distributes written application materials for enrollment, the SBC must be provided as part of those materials. For this purpose, written application materials include any forms or requests for information, in paper form or through a website or email, that must be completed for enrollment. If the plan or issuer does not distribute written application materials for enrollment (in either paper or electronic form), the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage.

- By first day of coverage (if there are any changes). If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the plan or issuer must update and provide a current SBC no later than the first day of coverage.

[4] See www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf or http://cciio.cms.gov/resources/files/Files2/02102012/sample-completed-sbcfinal.pdf.pdf.

- Special enrollees. The SBC must be provided to special enrollees no later than the date on which a summary plan description is required to be provided (90 days from enrollment).

- Upon renewal. If a plan or issuer requires participants and beneficiaries to actively elect to maintain coverage during an open season, or provides them with the opportunity to change coverage options in an open season, the plan or issuer must provide the SBC at the same time it distributes open season materials. If there is no requirement to renew (sometimes referred to as an "evergreen" election), and no opportunity to change coverage options, renewal is considered to be automatic and the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.[5]

- Upon request. The SBC must be provided upon request for an SBC or summary information about the health coverage as soon as practicable but in no event later than seven business days following receipt of the request.

**Q10: What are the circumstances in which an SBC may be provided electronically?**

With respect to group health plan coverage, an SBC may be provided electronically: (1) by an issuer to a plan, and (2) by a plan or issuer to participants and beneficiaries *who are eligible but not enrolled for coverage*, if:

- The format is readily accessible (such as in an html, MS Word, or pdf format);

- The SBC is provided in paper form free of charge upon request; and

- If the SBC is provided via an Internet posting (including on the HHS web portal), the issuer timely advises the plan (or the plan or issuer timely advises the participants and beneficiaries) that the SBC is available on the Internet and provides the Internet address. Plans and issuers may make this disclosure (sometimes referred to as the "e-card" or "postcard" requirement) by email.

An SBC may also be provided electronically by a plan or issuer to a participant or beneficiary *who is covered under a plan* in accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b-1. Those regulations include a safe harbor for disclosure through electronic media to participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties. Under the safe harbor, other individuals may also opt into electronic delivery.

[5] The final regulations provide an accommodation for insured coverage if the policy, certificate, or contract of insurance has not been renewed or reissued prior to the date that is 30 days prior to the first day of the new plan or policy year. In such cases, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

With respect to individual market coverage, a health insurance issuer must provide the SBC, in either paper or electronic form, in a manner that can reasonably be expected to provide actual notice. The SBC may not be provided in electronic form unless:

- The format is readily accessible;
- If the SBC is provided via an Internet posting, it is placed in a location that is prominent and readily accessible;
- The SBC is provided in an electronic form which can be retained and printed; and
- The issuer notifies the individual that the SBC is available free of charge in paper form upon request.

In addition, a health insurance issuer offering individual market coverage, that provides HealthCare.gov with all the content required to be provided in the SBC, will be deemed compliant with the requirement to provide an SBC upon request prior to application. However, issuers must provide the SBC in paper form upon request for a paper copy, and at all other times as specified in the regulations.

In addition, as stated in the regulations, unless the plan or issuer has knowledge of a separate address for a beneficiary, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form).

**Q11: Are issuers who have provided individual market plan information to HealthCare.gov in compliance with PHS Act section 2715 and its implementing regulations already?**

The deemed compliance provision in the regulation requires issuers in the individual market to provide all of the data elements that are needed to complete the SBC template to HealthCare.gov. If the issuer fails to provide all of the data elements, it would not be deemed to be in compliance with the regulation. Today, HealthCare.gov does not collect all of the elements of an SBC, such as information necessary to complete the coverage examples. However, HHS will collect this information and display it in the format of the SBC template by September 23, 2012, so that providing information to HealthCare.gov fulfills the deemed compliance provision.

**Q12: Can the Departments provide model language to meet the requirement to provide an e-card or postcard in connection with evergreen website postings?**

Yes. Plans and issuers have flexibility with respect to the postcard and may choose to tailor it in many ways. One example is:

> Availability of Summary Health Information
>
> As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.
>
> Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.
>
> The SBC is available on the web at: www.website.com/SBC. A paper copy is also available, free of charge, by calling 1-XXX-XXX-XXXX (a toll-free number).

**Q13: The regulations state that in order to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules in the claims and appeals regulations under PHS Act section 2719. Does this mean that the SBC must include a sentence on the availability of language assistance services?**

Yes, if the notice is sent to an address in a county in which ten percent or more of the population is literate only in a non-English language. The final SBC regulations provide that a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of the claims and appeals regulations are met.[6] The claims and appeals regulations outline three requirements that must be satisfied for notices sent to an address in a county in which ten percent or more of the population is literate only in a non-English language. In such cases, the plan or issuer is generally required to provide oral language services in the non-English language, provide notices upon request in the non-English language, and include in all English versions of the notices a statement in the non-English language clearly indicating how to access the language services provided by the plan or issuer.

Accordingly, plans and issuers must include, in the English versions of SBCs sent to an address in a county in which ten percent or more of the population is literate only in a non-English language, a statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the plan or issuer. In this

[6] See 26 CFR 54.9815-2719T(e), 29 CFR 2590.715-2719(e), and 45 CFR 147.136(e), originally published on July 23, 2010, at 75 FR 43330 and amended on June 24, 2011, at 76 FR 37208.

circumstance, the plan or issuer should include this statement on the page of the SBC with the "Your Rights to Continue Coverage" and "Your Grievance and Appeals Rights" sections.

Sample language for this statement is available on the model notice of adverse benefit determination at http://www.dol.gov/ebsa/IABDModelNotice2.doc. Current county-by-county data can be accessed at http://www.cciio.cms.gov/resources/factsheets/clas-data.html.

Even in counties where no non-English language meets the ten percent threshold, a plan or issuer can voluntarily include such a statement in the SBC in any non-English language. Moreover, nothing in the SBC regulations limits an individual's rights to meaningful access protections under other applicable Federal or State law, including Title VI of the Civil Rights Act of 1964.

**Q14: Where can plans and issuers find the written translations of the SBC template and the uniform glossary in the non-English languages?**

Written translations in Spanish, Chinese, Tagalog and Navajo will be available at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.

**Q15: Is an SBC permitted to simply substitute a cross-reference to the summary plan description (SPD) or other documents for a content element of the SBC?**

No, an SBC is not permitted to substitute a reference to the SPD or other document for any content element of the SBC. However, an SBC may include a reference to the SPD in the SBC footer. (For example, "Questions: Call 1-800-[insert] or visit us at www.[insert].com for more information, including a copy of your plan's summary plan description.") In addition, wherever an SBC provides information that fully satisfies a particular content element of the SBC, it may add to that information a reference to specified pages or portions of the SPD in order to supplement or elaborate on that information.

**Q16: Can a plan or issuer add premium information to the SBC form voluntarily?**

Yes. If a plan or issuer chooses to add premium information to the SBC, the information should be added at the end of the SBC form.

**Q17: Must the header and footer be repeated on every page of the SBC?**

No. If a plan or issuer chooses, it may include the header only on the first page of the SBC. In addition, a plan or issuer may include the footer only on the first and last page of the SBC, instead of on every page.

The OMB control numbers (which were displayed on the SBC template and the Departments' sample completed SBC to inform plans and issuers that the Departments had complied with the Paperwork Reduction Act) should not be displayed on SBCs provided by plans or issuers.

**Q18: For group health plan coverage, may the coverage period in the SBC header reflect the coverage period for the group plan as a whole, or must the coverage period be the period applicable to each particular individual enrolled in the plan?**

The SBC may reflect the coverage period for the group health plan as a whole. Therefore, if a plan is a calendar year plan and an individual enrolls on January 19, the coverage period is permitted to be the calendar year. Plans and issuers are not required to individualize the coverage period for each individual's enrollment.

**Q19: Can issuers and plans make minor adjustments to the SBC format, such as changing row and column sizes? What about changes such as rolling over information from one page to another, which was not permitted by the instructions?**

Minor adjustments are permitted to the row or column size in order to accommodate the plan's information, as long as the information is understandable. The deletion of columns or rows is not permitted.

Rolling over information from one page to another is permitted.

**Q20: Can plan names be generic, such as "Standard Option" or "High Option"?**

Yes, generic terms may be used.

**Q21: Can the issuer's name and the plan name be interchangeable in order?**

Yes.

**Q22: Can barcodes or control numbers be added to the SBC for quality control purposes?**

Yes, they can be added.

**Q23. Is the SBC required to include a statement about whether the plan is a grandfathered health plan?**

No, although plans may voluntarily choose to add a statement to the end of the SBC about whether the plan is a grandfathered health plan.

**Q24. My plan is moving forward to implement the SBC template for the first year of applicability. Are significant changes anticipated for 2014?**

No. The Departments identified in the preamble to the final regulations certain discrete changes that would be necessary for plan years (or, in the individual market, policy years) beginning after the first year of applicability. These changes include the addition of a minimum value statement and a minimum essential coverage statement, changes to be consistent with the Affordable Care Act's requirement to eliminate all annual limits on essential health benefits, and the Departments' intent to add additional coverage examples. The Departments are also considering

making some refinements consistent with these FAQs and other requests from plans and issuers for clarification and to promote operational efficiencies. No other changes are planned at this time.