



This document is scheduled to be published in the Federal Register on 12/30/2014 and available online at <http://federalregister.gov/a/2014-30243>, and on FDsys.gov

[Billing Codes: 4830-01-P; 4510-29-P; 4120-01-P]

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

REG-145878-14

RIN 1545-BM53

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210-AB69

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CMS-9938-P

45 CFR Part 147

RIN 0938-AS54

Summary of Benefits and Coverage and Uniform Glossary

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations regarding the summary of benefits and coverage (SBC) and the uniform glossary for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act. It proposes changes to the regulations that implement the

disclosure requirements under section 2715 of the Public Health Service Act to help plans and individuals better understand their health coverage, as well as to gain a better understanding of other coverage options for comparison. It proposes changes to documents required for compliance with section 2715 of the Public Health Service Act, including a template for the SBC, instructions, sample language, a guide for coverage example calculations, and the uniform glossary.

DATES: Comment date. Comments are due on or before **[INSERT DATE 60 DAYS AFTER PUBLICATION IN FEDERAL REGISTER]**.

ADDRESSES: Written comments on these proposed regulations and documents required for compliance (including the template, instructions, sample language, guide for coverage example calculations, and the uniform glossary) may be submitted to the Department of Labor as specified below. Any comment that is submitted will be shared with the Department of Health and Human Services and the Department of the Treasury, and will also be made available to the public. **WARNING:** Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Comments, identified by “Summary of Benefits and Coverage,” may be submitted by one of the following methods:

- **Federal eRulemaking Portal:** <http://www.regulations.gov>. Follow the instructions for submitting comments.

- Mail or Hand Delivery: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N-5653, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, Attention: Summary of Benefits and Coverage.

Comments received will be posted without change to <http://www.regulations.gov>, and available for public inspection at the Public Disclosure Room, N-1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington, DC 20210, including any personal information provided.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622-6080; Heather Raeburn or Tricia Beckmann, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (301) 492-4224 or (301) 492-4328.

Customer service information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's website (<http://www.dol.gov/ebsa>). In addition, information from HHS on private health insurance for consumers can be found on CMS's website (www.cms.gov/ccio) and information on health reform can be found at <http://www.healthcare.gov>.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act, Pub. L. 111-152, was

enacted on March 30, 2010 (these are collectively known as the “Affordable Care Act”). The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term “group health plan” includes both insured and self-insured group health plans.¹ The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by this reference are sections 2701 through 2728.

Section 2715 of the PHS Act, added by the Affordable Care Act, directs the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments) to develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage in compiling and providing a summary of benefits and coverage (SBC) that “accurately describes the benefits and coverage under the applicable plan or coverage.” PHS Act section 2715 also calls for the “development of standards for the definitions of terms used in health insurance coverage.”

In accordance with the statute, the Departments, in developing such standards, consulted with the National Association of Insurance Commissioners (referred to in this

¹ The term “group health plan” is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term “health plan,” as used in other provisions of title I of the Affordable Care Act. The term “health plan” does not include self-insured group health plans.

document as the “NAIC”) through “a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.”² On July 29, 2011, the NAIC provided its final recommendations to the Departments regarding the SBC. On August 22, 2011, the Departments published in the **Federal Register** proposed regulations (2011 proposed regulations) and an accompanying document with templates, instructions, and related materials for implementing the disclosure provisions under PHS Act section 2715.³ After consideration of all the comments received on the 2011 proposed regulations and accompanying documents, the Departments published joint final regulations to implement the disclosure requirements under PHS Act section 2715 on February 14, 2012 (2012 final regulations) and an accompanying document soliciting comments on templates, instructions, and related materials.⁴ The 2012 final regulations implemented standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage in compiling and providing an

² The NAIC convened a working group (NAIC working group) comprised of a diverse group of stakeholders. This working group met frequently for over one year while developing its recommendations. In developing its recommendations, the NAIC considered the results of various consumer testing sponsored by both insurance industry and consumer associations. Throughout the process, NAIC working group draft documents and meeting notes were displayed on the NAIC’s website for public review, and several interested parties filed formal comments. In addition to participation from the NAIC working group members, conference calls and in-person meetings were open to other interested parties and individuals and provided an opportunity for non-member feedback. See www.naic.org/committees_b_consumer_information.htm.

³ See proposed regulations, published at 76 FR 52442 (August 22, 2011) and guidance document published at 76 FR 52475 (August 22, 2011).

⁴ See final regulations, published at 77 FR 8668 (February 14, 2012) and guidance document published at 77 FR 8706 (February 14, 2012).

SBC that “accurately describes the benefits and coverage under the applicable plan or coverage” pursuant to PHS Act section 2715.

After the 2012 final regulations were published, the Departments released Frequently Asked Question (FAQs) regarding implementation of the SBC provisions as part of six issuances. The Departments released Affordable Care Act Implementation FAQs Parts VII, VIII, IX, X, XIV, and XIX to answer outstanding questions, including questions related to the SBC.⁵ These FAQs addressed questions related to compliance with the requirements of the 2012 final regulations, implemented additional safe harbors,⁶ and released updated SBC materials.

The Departments are issuing these proposed regulations, as well as a new set of proposed SBC templates, instructions, an updated uniform glossary, and other materials to incorporate some of the feedback the Departments have received and to make some improvements to the template. This will provide guidance necessary to plans and issuers as they continue to issue SBCs, and will improve the SBC for employers, participants and beneficiaries, and individuals and dependents for use as a tool in making important decisions regarding their health coverage. These modifications clarify when and how a

⁵ See Affordable Care Act Implementation FAQs Part VII (available at www.dol.gov/ebsa/faqs/faq-aca7.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html); Part VIII (available at www.dol.gov/ebsa/faqs/faq-aca8.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html); Part IX (available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html); Part X (available at www.dol.gov/ebsa/faqs/faq-aca10.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs10.html); Part XIV (available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html); and Part XIX (available at www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html).

⁶ Some of the enforcement safe harbors and transitions are proposed to be made permanent (several with modifications) by these proposed regulations. The Departments intend to use this rulemaking to develop a permanent approach to those issues and, thereby, discontinue all temporary enforcement policies that were used as a bridge to a permanent rule.

plan or issuer must provide an SBC, and streamline and shorten the SBC template while also adding certain additional elements that the Departments believe will be useful to consumers. The draft updated template, instructions, and supplementary materials are available at <http://cciio.cms.gov> and <http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html>. The Departments invite comments on all of the documents. Comments should be submitted as described above.

II. Overview of the Proposed Regulations

A. Requirement to Provide a Summary of Benefits and Coverage

1. Providing the SBC

Paragraph (a) of the 2012 final regulations implements the general disclosure requirement and sets forth the standards for who is required to provide an SBC, to whom, and when. PHS Act section 2715 generally requires that an SBC be provided to applicants, enrollees, and policyholders or certificate holders, at specified times. PHS Act section 2715(d)(3) places the responsibility to provide an SBC on “(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or (B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of ERISA).”⁷ Accordingly, the 2012 final regulations interpret PHS Act section 2715 to apply to both group health plans and health insurance

⁷ ERISA section 3(16) defines an administrator as: (i) the person specifically designated by the terms of the instrument under which the plan is operated; (ii) if an administrator is not so designated, the plan sponsor; or (iii) in the case of a plan for which an administrator is not designated and plan sponsor cannot be identified, such other person as the Secretary of Labor may by regulation prescribe.

issuers offering group or individual health insurance coverage. In addition, consistent with the statute, the 2012 final regulations hold the plan administrator of a group health plan responsible for providing an SBC. Under the 2012 final regulations, the SBC must be provided in writing and free of charge.

There are three general scenarios under which an SBC will be provided. An SBC will be provided: (1) by a group health insurance issuer to a group health plan; (2) by a group health insurance issuer or a group health plan to participants and beneficiaries; and (3) by a health insurance issuer to individuals and dependents in the individual market.

The 2012 final regulations specify timeframes according to which the SBC must be provided. After the 2012 regulations were published, the Departments were asked to clarify the meaning of the term “provided.” As the Departments stated in Affordable Care Act Implementation FAQs Part VIII, question 7, for purposes of providing an SBC in the context of these regulations, the term “provided” means sent. Accordingly, the SBC is timely if it is sent within seven business days, even if it is not received until after that period.⁸

a. Provision of the SBC by an Issuer to a Plan

Paragraph (a)(1)(i) of the 2012 final regulations requires a health insurance issuer offering group health insurance coverage to provide an SBC to a group health plan (or its sponsor) upon an application by the plan for health coverage. The issuer must provide the SBC as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. These proposed

⁸ See Affordable Care Act Implementation FAQs Part VIII, question 7, available at www.dol.gov/ebsa/faqs/faq-aca8.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

regulations would clarify when the health insurance issuer offering group health insurance coverage (or plan, if applicable, under paragraph (a)(1)(ii)) must provide the SBC again if the issuer already provided the SBC before application to any entity or individual. If the issuer provides the SBC before application for coverage pursuant to paragraph (a)(1)(i)(D) of the regulations (relating to SBCs upon request), the requirement to provide an SBC upon application is deemed satisfied and such issuer is not required to automatically provide another SBC upon application to the same entity or individual, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information required, a new SBC that includes the correct information must be provided upon application (that is, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application).

Under the 2012 final regulations and these proposed regulations, 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 issuer must update and provide a current SBC to the plan (or its sponsor) no later than the first day of coverage. If the information is unchanged, the issuer does not need to provide the SBC again in connection with coverage for that plan year, except upon request. These proposed rules would provide clarification with respect to how to satisfy the requirement to provide an SBC when the terms of coverage are not finalized. If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, an updated SBC is not required to be provided to the plan (or its sponsor) (unless an updated SBC is requested) until the first day of coverage. The updated SBC should

reflect the final coverage terms under the contract, certificate, or policy of insurance that was purchased.

b. Provision of the SBC by a Plan or Issuer to Participants and Beneficiaries

Under paragraph (a)(1)(ii) of the 2012 final regulations, a group health plan (including the plan administrator), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary⁹ with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.¹⁰ This includes individuals who are qualified beneficiaries under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA).¹¹ In Affordable Care Act Implementation FAQs Part VIII, question 8, the Departments clarified that while a qualifying event does not, itself, trigger a requirement to provide 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.¹² In this situation, a COBRA qualified beneficiary

⁹ ERISA section 3(7) defines a participant as: any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employers or members of such organization, or whose beneficiaries may be eligible to receive any such benefit. ERISA section 3(8) defines a beneficiary as: a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

¹⁰ With respect to insured group health plan coverage, PHS Act section 2715 generally places the obligation to provide an SBC on both a plan and issuer. As discussed below, under section III.A.1.d., “Special Rules to Prevent Unnecessary Duplication with Respect to Group Health Coverage”, if either the issuer or the plan provides the SBC, both will have satisfied their obligations. As they do with other notices required of both plans and issuers under Part 7 of ERISA, Title XXVII of the PHS Act, and Chapter 100 of the Code, the Departments expect plans and issuers to make contractual arrangements for sending SBCs. Accordingly, the remainder of this preamble generally refers to requirements for plans or issuers.

¹¹ See Affordable Care Act Implementation FAQs Part VIII, question 7, available at www.dol.gov/ebsa/faqs/faq-aca8.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

¹² 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).

who has elected coverage must be provided an SBC just as a similarly situated non-COBRA beneficiary must be provided with one. 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 a requirement to provide an SBC.¹³

If a plan or issuer distributes any written application materials for enrollment, including any forms or requests for information (in paper form or through a website or email) that must be completed for enrollment, the plan or issuer must provide the SBC as part of those materials. 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 for the participant or any beneficiaries. If there is any change to the information required to be in the SBC that was provided upon application for coverage and before the first day of coverage, the plan or issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

These proposed rules would clarify when a plan or issuer must provide the SBC again if the plan or issuer already provided the SBC prior to application. If the plan or issuer provides the SBC prior to application for coverage, the plan or issuer is not required to automatically provide another SBC upon application, if there is no change to the information required to be in the SBC. If there is any change to the information required to be in the SBC by the time the application is filed, the plan or issuer must

¹³ See 26 CFR 54.4980B-5, Q&A-4(b).

update and provide a current SBC as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

These proposed rules also would provide clarification with respect to how to satisfy the requirement to provide an SBC when the terms of coverage are not finalized. If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, the plan or issuer is not required to provide an updated SBC (unless an updated SBC is requested) until the first day of coverage. The updated SBC should reflect the final coverage terms under the contract, certificate, or policy of insurance that was purchased.

Under the 2012 final regulations, the plan or issuer must also provide the SBC to individuals enrolling through a special enrollment period, also called special enrollees.¹⁴ Special enrollees must be provided the SBC no later than when a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is 90 days from enrollment. To the extent individuals who are eligible for special enrollment and are contemplating their coverage options would like to receive SBCs earlier, they may always request an SBC with respect to any particular plan, policy, or benefit package and the SBC is required to be provided as soon as practicable, but in no event later than seven business days following receipt of the request (as discussed more fully below).

c. Provision of the SBC Upon Request in Group Health Coverage

¹⁴ Regulations regarding special enrollment are available at 26 CFR 54.9801-6, 29 CFR 2590.701-6, and 45 CFR 146.117.

A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan or its sponsor (and a plan or issuer must provide the SBC to a participant or beneficiary) 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. The SBC must be provided upon request to participants, beneficiaries, and plans (or plan sponsors), including prior to submitting an application for coverage, because the SBC provides information that not only helps consumers and employers understand their coverage, but also helps consumers and employers compare coverage options prior to selecting coverage. Health insurance issuers offering individual market coverage must also provide the SBC to individuals upon request, according to the same timeframe, to allow consumers the same ability to compare coverage options in the individual market as the group market.

Since the issuance of the 2012 final regulations, the Departments have continued to receive questions about providing SBCs upon request, including whether issuers are required to provide SBCs to plans or their sponsors who are “shopping” for coverage from different issuers but have not yet submitted an application for coverage. In Affordable Care Act Implementation FAQs Part IX, question 4, the Departments reiterated that an SBC must be provided upon request for an SBC or “summary information about a health insurance product.” The latter phrase is intended to ensure that persons who do not ask exactly for a “summary of benefits and coverage” still receive one when they explicitly ask for a summary document with respect to a specific health

coverage product.¹⁵ The FAQ also referred to other guidance outlining the circumstances in which an SBC may be provided electronically, to assist in reducing the burden of providing multiple SBCs in paper form when requested. Additional information on electronic disclosure of SBCs is discussed later in this preamble.

d. Special Rules to Prevent Unnecessary Duplication with Respect to Group Health Coverage

Paragraph (a)(1)(iii) of the 2012 final regulations includes three special rules to streamline provision of the SBC and avoid unnecessary duplication with respect to group health coverage. The first provides that the requirement to provide an SBC generally will be considered satisfied for all applicable entities if it is provided by any entity, so long as all timing and content requirements are satisfied. The second provides that a single SBC may be provided to a participant and any beneficiaries at the participant's last known address. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address. Third, the 2012 final regulations provide that SBCs are not required to be provided automatically upon renewal for each benefit package option in group health plans that offer multiple benefit packages. Rather, a plan or issuer is required to provide an SBC automatically upon renewal or reissuance only with respect to the benefit package in which a participant or beneficiary is enrolled. In cases in which an issuer will automatically re-enroll participants and beneficiaries, these proposed rules propose to add that a new SBC is required to be provided with respect to the plan or

¹⁵ The FAQ stated that other general questions about coverage options or discussions about health products do not trigger the requirement to provide an SBC.

product in which a participant or beneficiary will be automatically enrolled in accordance with the same timing requirements that apply to a renewal or reissuance. Consistent with the 2012 final regulations, if a participant or beneficiary requests an SBC with respect to one or more other benefit packages for which he or she is eligible, that requested SBC or SBCs must be provided as soon as practicable, but in no event later than seven business days following the receipt of the request.

In addition to retaining these three existing special rules, these proposed regulations would add an additional provision to ensure participants receive information while preventing unnecessary duplication. This would address circumstances where an entity required to provide an SBC with respect to an individual has entered into a binding contract with another party to provide the SBC to the individual. In such a case, the proposed regulations state that the entity would be considered to satisfy the requirement to provide the SBC with respect to the individual if specified conditions are met:

- (1) The entity monitors performance under the contract;¹⁶
- (2) If the entity has knowledge that the SBC is not being provided in a manner that satisfies the requirements of this section and the entity has all information necessary to correct the noncompliance, the entity corrects the noncompliance as soon as practicable; and

¹⁶ The selection and monitoring of service providers for a group health plan, including parties assuming responsibility to complete, provide information for, or deliver SBCs, is a fiduciary act subject to prudence and loyalty duties and prohibited transaction provisions of ERISA. No single fiduciary procedure will be appropriate in all cases; the procedure for selecting and monitoring service providers may vary in accordance with the nature of the plan and other facts and circumstances relevant to the choice of the service provider. More general information on hiring and monitoring service providers is contained in the Department of Labor publication “Understanding Your Fiduciary Responsibilities Under a Group Health Plan,” which is available on the Department’s website at: www.dol.gov/ebsa/publications/ghpfiduciaryresponsibilities.html.

(3) If the entity has knowledge the SBC is not being provided in a manner that satisfies the requirements of this section and the entity does not have all information necessary to correct the noncompliance, the entity communicates with participants and beneficiaries who are affected by the noncompliance regarding the noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

The proposed regulations would also add a provision to prevent unnecessary duplication with respect to a group health plan that uses two or more insurance products provided by separate issuers to insure benefits under the plan. The proposed regulations would place responsibility for providing complete SBCs with respect to the plan in such a case on the group health plan administrator. This provision of the proposed regulations states that the group health plan administrator may contract with one of its issuers (or other service providers) to provide the SBC; however, absent a contract to perform the function, an issuer has no obligation to provide an SBC containing information for benefits that it does not insure.

The Departments recognize that a plan sponsor may purchase an insurance product for certain coverage from a particular issuer and purchase a separate insurance product or self-insure with respect to other coverage (such as outpatient prescription drug coverage). In these circumstances, the first issuer may or may not know of the existence of other coverage, or whether the plan sponsor has arranged the two benefit packages as a single plan or two separate plans. To address these arrangements, these proposed rules propose that, with respect to a group health plan that uses two or more insurance products provided by separate issuers, the group health plan administrator is responsible for providing complete SBCs with respect to the plan. The group health plan administrator

may contract with one of its issuers (or other service providers) to perform that function. Absent a contract to perform the function, an issuer has no obligation to provide coverage information for benefits that it does not insure.

The Departments published an FAQ on May 11, 2012¹⁷ regarding the responsibility to provide an SBC in situations where plans may have benefits provided by more than one issuer. This FAQ provides an enforcement safe harbor for a group health plan that uses two or more insurance products provided by separate issuers with respect to a single group health plan. Under this enforcement safe harbor, the group health plan administrator may synthesize the information into a single SBC or provide multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements. In such circumstances, the plan administrator should take steps (such as a cover letter or a notation on the SBCs themselves) to indicate that the plan provides coverage using multiple insurance products and that individuals may contact the plan administrator for more information (and provide the contact information). The Departments extended this enforcement safe harbor for one year on April 23, 2013,¹⁸ and indefinitely on May 2, 2014,¹⁹ and reiterate that the safe harbor continues to apply. The Departments seek comment on whether to codify this policy in the regulation.

e. Provision of the SBC by an Issuer Offering Individual Market Coverage

¹⁷ See Affordable Care Act Implementation FAQs Part IX, question 10, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

¹⁸ Affordable Care Act Implementation FAQs Set XIV, question 5, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html.

¹⁹ Affordable Care Act FAQ Set XIX, question 8, available at www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html.

Paragraph (a)(1)(iv) of the HHS 2012 final regulations sets forth standards applicable to individual health insurance coverage, under which the provision of the SBC by an issuer offering individual market coverage largely parallels the group market requirements described above, with only those changes necessary to reflect the differences between the two markets. The SBC must be provided upon application. That is, a health insurance issuer offering individual health insurance coverage must provide an SBC to an individual or dependent upon receiving an application for any health insurance policy, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. 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 issuer must update and provide a current SBC to an individual or dependent no later than the first day of coverage. These proposed rules would clarify when the issuer must provide the SBC again if the issuer already provided the SBC prior to application. If the issuer provides the SBC prior to application for coverage, the issuer is not required to automatically provide another SBC upon application, if there is no change to the information required to be in the SBC. If there is any change to the information required to be in the SBC that was provided prior to application for coverage by the time the application is filed, the issuer must update and provide a current SBC to the same individual or dependent as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. Under the 2012 final regulations, a health insurance issuer offering individual health insurance coverage must provide the SBC to an individual or dependent upon request for the SBC or summary information about the

health insurance product, as soon as practicable, but in no event later than seven business days following receipt of the request.

These proposed rules would also address situations where an issuer offering individual market insurance coverage, consistent with applicable Federal and State law, automatically re-enrolls an individual and any dependents into a different plan or product than the plan in which these individuals were previously enrolled. If the issuer automatically re-enrolls an individual covered under a policy, certificate, or contract of insurance (including every dependent) into a policy, certificate, or contract of insurance under a different plan or product, HHS proposes that the issuer would be required to provide an SBC with respect to the coverage in which the individual (including every dependent) will be enrolled, consistent with the timing requirements that apply when the policy is renewed or reissued.

f. Special Rules to Prevent Unnecessary Duplication With Respect to Individual Health Insurance Coverage

In paragraph (a)(1)(v) of the 2012 final regulations, the Secretary of HHS states that, if a single SBC is provided to an individual and any dependents at the individual's last known address, then the requirement to provide the SBC to the individual and any dependents is generally satisfied. However, if a dependent's last known address is different than the individual's last known address, a separate SBC is required to be provided to the dependent at the dependent's last known address.

Student health insurance coverage is a type of individual health insurance coverage provided pursuant to a written agreement between an institution of higher education and a health insurance issuer to students enrolled in that institution of higher

education, and their dependents, that meet certain specified conditions.²⁰ These proposed rules propose to extend an anti-duplication rule similar to that provided with respect to group health coverage to student health insurance coverage, as defined in in 45 CFR 147.145(a). Specifically, HHS proposes that the requirement to provide an SBC with respect to an individual will be considered satisfied for an entity (such as an institution of higher education) if another party (such as a health insurance issuer) provides a timely and complete SBC to the individual. The Departments are also soliciting comments on whether or not a requirement to monitor the provisioning of the SBC in this circumstance should be added.

2. Content

PHS Act section 2715(b)(3) generally provides that the SBC must include:

- a. Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
- b. A description of the coverage, including cost sharing, for each category of essential health benefits, and other benefits as identified by the Departments;
- c. The exceptions, reductions, and limitations on coverage;
- d. The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
- e. The renewability and continuation of coverage provisions;

²⁰ See 45 CFR 147.145, published at 77 FR 16453 (March 21, 2012).

- f. A coverage facts label that includes examples to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost sharing based on recognized clinical practice guidelines;
- g. A statement of whether the plan or coverage provides minimum essential coverage (MEC) as defined under section 5000A(f) of the Code, and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage is not less than 60% of such costs;
- h. A statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage; and
- i. A contact number to call with questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

Consistent with the Departments' authority to develop standards with respect to the SBC and with the statutory requirement to consult with the NAIC and other stakeholders, after considering recommendations by the NAIC and comments received on the 2011 proposed regulations, the 2012 final regulations added three content elements: (1) for plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of the network providers; (2) for plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage under the plan or coverage; and (3) an Internet address for obtaining the

uniform glossary, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies of the uniform glossary are available.

The Departments have received several questions related to content requirements under the 2012 final regulations. One such question relates to the statements about whether a plan or coverage provides MEC, as defined under section 5000A(f) of the Code, and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable minimum value (MV) requirements. The preamble to the 2012 final regulations stated that future guidance would address these statements. In April 2013, the Departments issued an updated SBC template (and sample completed SBC) with the addition of statements of whether the plan or coverage provides MEC (as defined under section 5000A(f) of the Code) and whether the plan or coverage meets the MV requirements.²¹ In Affordable Care Act Implementation FAQs Part XIV, issued contemporaneously with the updated SBC template, the Departments stated this language is required to be included in SBCs provided with respect to coverage beginning on or after January 1, 2014.²²

An FAQ issued at that time stated that if a plan or issuer was unable to modify the SBC template for these disclosures, the Departments will not take any enforcement action

²¹ See Affordable Care Act Implementation FAQs Part XIV, question 1, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html.

²² The guidance with respect to statements regarding MEC and MV was originally issued for SBCs provided with respect to coverage beginning on or after January 1, 2014, and before January 1, 2015 (referred to as the "second year of applicability"). See Affordable Care Act Implementation FAQs Part XIV, question 1, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html. This guidance was extended to be applicable until further guidance was issued. See Affordable Care Act Implementation FAQs Part XIX, question 7, available at www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html

against a plan or issuer for using the original template authorized at the time the 2012 final regulations were issued, provided that the SBC was furnished with a cover letter or similar disclosure stating whether the plan or coverage does or does not provide MEC and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage does or does not meet the MV standard under the Affordable Care Act.²³ The Departments decline to extend this temporary enforcement safe harbor. Accordingly, effective for SBCs provided in accordance with the applicability date described below for these proposed rules, the statements regarding MEC and MV are required to be included in the SBC. These statements have been modified for added clarity and relevance for consumers, including consumers in the individual market. As of the applicability date described below, the option previously available to include this information in a cover letter or similar disclosure furnished with the SBC is no longer available.

Under section 1303(b)(3)(A) of the Affordable Care Act and implementing regulations at 45 CFR 156.280(f), a QHP issuer that elects to offer a QHP that provides coverage of abortion services for which public funding is prohibited (non-excepted abortion services) must provide a notice to enrollees, as part of the SBC provided at the time of enrollment, of coverage of such services.

In the interest of increasing transparency for consumers shopping for coverage, and to assist issuers with meeting applicable disclosure requirements under section 1303(b)(3)(A) of the Affordable Care Act and its implementing regulations, we are

²³ See Affordable Care Act Implementation FAQs Part XIV, question 2, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html.

updating the SBC template published contemporaneously with these proposed rules. These proposed rules would require a QHP issuer to disclose on the SBC whether abortion services are covered or excluded and whether coverage is limited to services for which federal funding is allowed (excepted abortion services). The draft instruction guide for individual health insurance, released concurrently with these proposed rules, indicates that coverage of abortion services must be described in the “services your plan does not cover” or “other covered services” section. We seek comments on this guidance, including whether coverage of abortion services should be included in another section of the template, such as the table occurring immediately prior.

Neither the 2012 final regulations nor these proposed regulations require the SBC to include premium information. The Departments previously stated their understanding that it is administratively and logistically complex to convey premium information in an SBC due to a number of variables, including, for example, when premiums differ based on family size; when, in the group market, employer contributions impact cost of coverage paid by participants and beneficiaries; and when, for coverage sold through an individual market Exchange, advance payments of the premium tax credit impact the cost of coverage paid by individuals and dependents. In Affordable Care Act Implementation FAQs Part VIII, question 16, the Departments clarified that a plan or issuer may choose

to add premium information to the SBC.²⁴ If a plan or issuer wishes to include this information, it should be added at the end of the SBC template.²⁵

As mentioned above, the statute provides that the SBC must include “a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.” The 2012 final regulations state the SBC must include “contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance).” Questions have arisen as to whether this provision of the statute and regulations requires that all plans and issuers must post underlying plan documents automatically on an Internet website.

These proposed rules would clarify that all plans and issuers must include on the SBC contact information for questions. However, because the statutory language regarding Internet posting uses the terms “individual coverage policy” and “group certificate of coverage,” which we interpret to refer only to insurance, these proposed regulations propose that only issuers must also include an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. The Departments note that this proposal would require these

²⁴ See Affordable Care Act Implementation FAQs Part VIII, question 16, available at www.dol.gov/ebsa/faqs/faq-aca8.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

²⁵ In accordance with section 1303 (b)(3)(B) of the Affordable Care Act and 45 CFR 156.280(f)(2), if the SBC provided at the time of enrollment notice includes the QHP premium amount, it must display only the total premium for the plan, inclusive of all covered benefits and services.

documents to be easily available to individuals, plan sponsors, and participants and beneficiaries shopping for coverage prior to submitting an application for coverage. For the group market only, because the actual “certificate of coverage” is not available until after the plan sponsor has negotiated the terms of coverage with the issuer, an issuer is permitted to satisfy this requirement with respect to plan sponsors that are shopping for coverage by posting a sample group certificate of coverage for each applicable product. After the actual certificate of coverage is executed, it must be easily available to plan sponsors and participants and beneficiaries via an Internet web address. The Departments invite comments on this approach, including the costs and benefits of also requiring self-insured plans to post underlying plan documents on the Internet.

The Departments also note that, separate from the SBC requirement, provisions of other applicable law require disclosure of plan documents and other instruments governing the plan. For example, ERISA section 104 and the Department of Labor’s implementing regulations²⁶ provide that, for plans subject to ERISA, the plan documents and other instruments under which the plan is established or operated must generally be furnished by the plan administrator to plan participants²⁷ upon request. In addition, the Department of Labor’s claims procedure regulations (applicable to ERISA plans), as well as the Departments’ claims and appeals regulations under the Affordable Care Act (applicable to all non-grandfathered group health plans and health insurance issuers in the

²⁶ 29 CFR 2520.104b-1.

²⁷ ERISA section 3(7) defines a “participant” to include any employee or former employee who is or may become eligible to receive a benefit of any type from an employee benefit plan or whose beneficiaries may be eligible to receive any such benefit. Accordingly, employees who are not enrolled but are, for example, in a waiting period for coverage, or who are otherwise shopping amongst benefit package options at open season, generally are considered plan participants for this purpose.

group and individual markets),²⁸ set forth rules regarding claims and appeals, including the right of claimants (or their authorized representatives) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided by the plan or issuer, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. Plans and issuers must continue to comply with these provisions and any other applicable laws.

Section 2715(b)(3)(F) of the PHS Act also requires that an SBC contain a “coverage facts label.” For ease of reference, the 2012 final regulations used the term “coverage examples” in place of the statutory term. Consumer testing performed on behalf of the NAIC²⁹ demonstrated that the coverage examples facilitated individuals’ understanding of the benefits and limitations of a plan or policy and helped them make more informed choices about their options. That testing also showed that individuals were able to comprehend that the examples were only illustrative. Additionally, while some plans provide useful coverage calculators to their enrollees to help them make health coverage decisions, they are not uniform across all plans and most are not available to individuals prior to enrollment, making it difficult for individuals and employers to make coverage comparisons.

²⁸ 29 CFR 2560.503–1. *See also* 29 CFR 2590.715–2719(b)(2)(i) and 45 CFR 147.136(b)(2)(i), requiring nongrandfathered plans and issuers to incorporate the internal claims and appeals processes set forth in 29 CFR 2560.503–1.

²⁹ A summary of the focus group testing done by America’s Health Insurance Plans is available at: http://www.naic.org/documents/committees_b_consumer_information_101012_ahip_focus_group_summary.pdf, a summary of the focus group testing done by Consumers Union on the coverage examples is available at: http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/08/A_New_Way_of_Comparing_Health_Insurance.pdf.

The Departments have taken a phased approach to implementing the coverage examples. The 2012 final regulations require the SBC to include two coverage examples: having a baby (normal delivery) and routine maintenance of well-controlled type 2 diabetes. Each benefit scenario represents a hypothetical situation consisting of a sample treatment plan and medical costs, based on national average allowed charges, for each of the conditions stated above. Each example describes the sample care costs and how much the hypothetical patient will be responsible for paying, including deductibles, copayments and coinsurance.

In addition to the two existing coverage examples, these proposed regulations would require a third coverage example – a simple foot fracture (with emergency room visit). This example is proposed as a health problem that most individuals could experience (whereas having a baby and type 2 diabetes affect a subset of the population). Comments are welcome on the choice of this coverage example.

In documents published contemporaneously with these proposed rules, the Departments are publishing draft updated claims and pricing data underlying the two existing coverage examples as well as a narrative description and claims and pricing data associated with the third proposed coverage example.³⁰ These materials would provide plans and issuers with the specific information necessary to simulate benefits covered under the plan or policy for the coverage example portion of the SBC (including relevant medical items and services, dates of service, billing codes, and allowed charges). The Departments invite comment on all aspects of the benefits scenario proposed as a third

³⁰ For further discussion of changes to the claims and pricing data underlying the two existing coverage examples, as well as the claims and pricing data with respect to the new coverage example, see section III later in this preamble.

coverage example and on all aspects of the coverage example materials made available on the HHS website contemporaneously with the publication of these proposed regulations.

In May 2012, the Departments announced the development of a calculator that plans and issuers could use as a safe harbor for the first year of applicability to complete the coverage examples in a streamlined fashion.³¹ The calculator allows plans and issuers to input a discrete number of informational elements about the benefit package, taken from data fields used to populate the “Important Questions” and “Common Medical Events” chart sections of the SBC template.” The output of the calculator is a coverage example that can be added to the SBC. On its website, HHS provided the coverage examples calculator, instructions for using the calculator, the algorithm that was used to create the calculator, and a checklist providing information on the inputs needed to use the coverage calculator.

The original FAQ regarding the coverage example calculator stated that because using a limited number of inputs in the calculator will be less accurate than the results that a plan or issuer could obtain by processing the full list of claims associated with each coverage example through the plan’s or issuer’s system, the calculator would be allowed as a transitional tool for the first year of applicability of the SBC requirements. Use of the coverage example calculator was subsequently extended for the second year of applicability, and later extended until superseded by further guidance.³² Given the

³¹ See ACA Implementation FAQ Set IX, question 9, available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

³² The FAQ with respect to the coverage example calculator was originally issued for SBCs provided for coverage beginning before January 1, 2014 (referred to as the “first year of applicability”). See Affordable

complexity of the existing coverage examples, the addition of a proposed new, third coverage example to the SBC requirements, and the fact that all coverage examples are merely illustrative and will not be an accurate predictor of a specific individual's actual costs, the Departments are proposing that the coverage example calculator be authorized for continued use. The Departments invite comments on this proposal.

3. Appearance

PHS Act section 2715 sets forth standards related to the appearance and language of the SBC. Specifically, the statute provides that the SBC is to be presented in a uniform format, in a culturally and linguistically appropriate manner utilizing terminology understandable by the average plan enrollee, that does not exceed four double-sided pages in length, and does not include print smaller than 12-point font. Since the issuance of the 2011 proposed regulations, plans and issuers have informed the Departments that they are concerned about including all of the required information in the SBC while also satisfying the limitation on the length of the document of four double-sided pages.

The instruction guides for completing the SBC template (issued contemporaneously with the 2012 final regulations) included a special rule stating that, to the extent a plan's terms that are required to be in the SBC template cannot reasonably be

Care Act Implementation FAQs Part IX, question 9, available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html. It was extended for SBCs provided for coverage beginning on or after January 1, 2014, and before January 1, 2015 (referred to as the "second year of applicability"), in Affordable Care Act Implementation FAQs Part XIV, question 5 (available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html) and later extended until superseded by further guidance is issued in Affordable Care Act Implementation FAQs Part XIX, question 7 (available at www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html).

described in a manner consistent with the template format and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible. Such situations may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is contemplated by the template and associated instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where the effects of a health flexible spending arrangement (health FSA) or a health reimbursement arrangement (HRA) are being described, or if a plan provides different cost sharing based on participation in a wellness program. The new SBC template that is being published contemporaneously with these proposed regulations eliminates some information from the SBC that is not required by statute based on comments from stakeholders, which is intended to make it easier for plans to include all of the required information in the SBC while also satisfying the statutory page limit. These reductions are significant; the sample completed template has been reduced from four double-sided pages to two and a half double-sided pages. The Departments invite comments on whether the modifications maintain critical information while shortening it enough to ensure that SBCs do not extend beyond the statutory page limit and, if not, what other changes should be made to ensure the minimum content, appearance, and language requirements are met while also providing consistency in formatting to allow comparisons for individuals. Comments are invited on potential ways to reconcile the statutory page limit with the statutory contents, appearance, and format requirements, particularly the need for the summary to present information in an understandable, accurate, and meaningful way that facilitates

comparisons of health options, including those that have disparate and comparatively complex features. Specifically, comments are invited on the sorts of plans that have difficulty meeting the statutory limit, and what other sorts of accommodations may be appropriate for those plans.

Paragraph (a)(3) of the 2012 final regulations requires plans and issuers to provide the SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretaries in guidance. A guidance document published contemporaneously with the 2012 final regulations served as such guidance specified by the Secretaries, and stated that SBCs provided in connection with group health plan coverage may be provided either as a stand-alone document or in combination with other summary materials (for example, a summary plan description (SPD)), if the SBC information is intact and prominently displayed at the beginning of the materials (such as immediately after the Table of Contents in an SPD) and in accordance with the timing requirements for providing an SBC.³³ For health insurance coverage offered in the individual market, the SBC must be provided as a stand-alone document, but HHS notes that it can be included in the same mailing as other plan materials. These proposed rules do not make any changes to these requirements.

In Affordable Care Act Implementation FAQs Part VIII, question 8, the Departments stated that an SBC provided in connection with a group health plan may include a reference to the SPD (although not as a substitute for any required content

³³ Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials; and Guidance for Compliance, 77 FR 8706, 8707 (February 14, 2012).

element of the SBC).³⁴ Another FAQ provided that for SBCs provided in connection with coverage in the individual market, while it is not permitted to substitute a reference to any other document for any content element of the SBC, an SBC may include a reference to another document in the SBC footer.³⁵ 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 other documents in order to supplement or elaborate on that information. As stated in the previous FAQs, SBCs provided in connection with a group health plan may include a reference to the SPD or other documents and SBCs provided in connection with individual market coverage may reference other documents to supplement or elaborate on information in the SBC.

Affordable Care Act Implementation FAQs Part IX, question 7, addressed combining SBCs or SBC elements to provide a side-by-side comparison.³⁶ Some plans or issuers provide web-based or print materials to illustrate the differences between benefit package options (including comparison charts and broker comparison websites). Issuers and plans (and agents and brokers working with such plans) may display SBCs, or parts of SBCs, in a way that facilitates comparisons of different benefit package options by individuals and employers shopping for coverage. For example, on a website, viewers could be allowed to select a comparison of only the deductibles, out-of-pocket limits, or

³⁴ See Affordable Care Act Implementation FAQs Part VIII, question 8, available at www.dol.gov/ebsa/faqs/faq-aca8.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

³⁵ See Affordable Care Act Implementation FAQs Part IX, question 5, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

³⁶ See Affordable Care Act Implementation FAQs Part IX, question 7, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

other cost sharing information relating to several benefit package options. This could be achieved by providing the information from the Answers column in the “What is the overall deductible?” row of the SBC for several benefit packages, but without having to repeat the first “Important Questions” and “Why this Matters” columns, or the other content rows, of the SBC for each of the benefit packages. However, such a chart, website, or other comparison would not, itself, satisfy the requirements under PHS Act section 2715 and the 2012 final regulations to provide the SBC. The full SBC for each of the benefit packages included in the comparison view or tool must be made available in accordance with the statute and regulations.

4. Form

a. Group health plan coverage

To facilitate faster and less burdensome disclosure of the SBC, and to be consistent with PHS Act section 2715(d)(2), which permits disclosure in either paper or electronic form, the 2012 final regulations set forth rules to permit greater use of electronic transmittal of the SBC. For SBCs provided electronically by a plan or issuer to participants and beneficiaries, the 2012 final regulations make a distinction between a participant or beneficiary who is already covered under the group health plan, and a participant or beneficiary who is eligible for coverage but not enrolled in a group health plan. This distinction should provide new flexibility in some circumstances, while also ensuring adequate consumer protections. For participants and beneficiaries who are already covered under the group health plan, the 2012 final regulations permit provision of the SBC electronically if the requirements of the Department of Labor’s regulations at 29 CFR 2520.104b-1 are met. (Paragraph (c) of those regulations includes an electronic

disclosure safe harbor.³⁷⁾ For participants and beneficiaries who are eligible for but not enrolled in coverage, the 2012 final regulations permit the SBC to be provided electronically if the format is readily accessible and a paper copy is provided free of charge upon request. Additionally, to reduce paper copies that may be unnecessary, if the electronic form is an Internet posting, the plan or issuer must timely advise the individual in paper form (such as a postcard) or email that the documents are available on the Internet, provide the Internet address, and notify the individual that the documents are available in paper form upon request. The Departments note that the rules for participants and beneficiaries who are eligible for but not enrolled in coverage are substantially similar to the requirements for an issuer providing an electronic SBC to a group health plan (or its sponsor) under paragraph (a)(4)(i) of the regulations. Finally, plans, and participants and beneficiaries (both those covered and those eligible but not enrolled) have the right to receive an SBC in paper format, free of charge, upon request.

In Affordable Care Act Implementation FAQs Part IX, question 1, the Departments adopted an additional safe harbor related to electronic delivery of SBCs.³⁸ That FAQ stated that SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. The FAQ also stated SBCs also may be provided electronically to

³⁷ On April 7, 2011, the Department of Labor published a Request for Information regarding electronic disclosure at 76 FR 19285. In it, the Department of Labor stated that it is reviewing the use of electronic media by employee benefit plans to furnish information to participants and beneficiaries covered by employee benefit plans subject to ERISA. Because these proposed regulations propose to adopt the ERISA electronic disclosure rules by cross-reference, any changes that may be made to 29 CFR 2520.104b-1 in the future would also apply to the SBC.

³⁸ See Affordable Care Act Implementation FAQs Part IX, question 4, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request. These proposed regulations would include this additional safe harbor into the applicable regulations.

After the publication of the 2012 final regulations, the Departments were asked to provide model language to meet the requirement to advise participants and beneficiaries that the SBC is available on the Internet. In Affordable Care Act FAQs Part VIII, question 12, the Departments provided the following model language:³⁹

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).

The FAQ also stated that plans and issuers have flexibility with respect to the postcard and may choose to tailor it in many ways.

b. Individual health insurance coverage and self-insured non-Federal governmental plans

The HHS 2012 final regulations established a provision under paragraph (a)(4)(iii)(C) that deems health insurance issuers in the individual market to be in

³⁹ See Affordable Care Act Implementation FAQs Part VIII, question 12, available at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

compliance with the requirement to provide the SBC to an individual requesting summary information about a health insurance product prior to submitting an application for coverage if the issuer provides the content required under paragraph (a)(2) of the regulations to the federal health reform Web portal described in 45 CFR 159.120. Issuers must submit all of the content required under paragraph (a)(2), as specified in guidance by the Secretary, to be deemed compliant with the requirement to provide an SBC to an individual requesting summary information prior to submitting an application for coverage. HHS intends to continue to facilitate the operation of this deemed compliance option for individual market issuers. An issuer must provide all SBCs other than the “shopper” SBC contemplated in the deemed compliance provision as required under the 2012 final regulations (and any future final regulations), including providing the SBC at the time of application and renewal.

The Departments note that consistent with the 2012 final regulations, an issuer in the individual market must provide the SBC in a manner that can reasonably be expected to provide actual notice regardless of the format. An issuer in the individual market satisfies the form requirements set forth in the 2012 final regulations if it does at least one of the following: (1) hand-delivers a printed copy of the SBC to the individual or dependent; (2) mails a printed copy of the SBC to the mailing address provided to the issuer by the individual or dependent; (3) provides the SBC by email after obtaining the individual’s or dependent’s agreement to receive the SBC or other electronic disclosures by email; (4) posts the SBC on the Internet and advises the individual or dependent in paper or electronic form, in a manner compliant with 45 CFR 147.200(a)(4)(iii)(A)(1) through (3), that the SBC is available on the Internet and includes the applicable Internet

address; or (5) provides the SBC by any other method that can reasonably be expected to provide actual notice.

The 2012 final regulations also provide that the obligation to provide an SBC cannot be satisfied electronically in the individual market unless: the format is readily accessible; the SBC is displayed in a location that is prominent and readily accessible; the SBC is provided in an electronic form that can be electronically retained and printed; the SBC is consistent with the appearance, content and language requirements; and the issuer notifies the individual that a paper SBC is available upon request without charge.

These proposed rules would clarify the form and manner for SBCs provided by a self-insured non-Federal governmental plan. Such SBCs may be provided in paper form. Alternatively, such SBCs may be provided electronically if the plan conforms to either the substance of the provisions applicable to ERISA plans (in paragraph (a)(4)(ii) of the regulations) or to individual health insurance coverage (in paragraph (a)(4)(iii) of the regulations).

5. Language

PHS Act section 2715(b)(2) provides that standards shall ensure that the SBC “is presented in a culturally and linguistically appropriate manner.” The 2012 final regulations provide that a plan or issuer for this purpose is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 45 CFR 147.136(e), implementing standards for the form and manner of notices related to internal claims appeals and external review, are met as applied to the SBC.⁴⁰ At the time

⁴⁰ See 75 FR 43330 (July 23, 2010), as amended by 76 FR 37208 (June 24, 2011).

of publication of these proposed regulations, 268 U.S. counties (78 of which are in Puerto Rico) meet this threshold. The overwhelming majority of these are Spanish; however, Chinese, Navajo, and Tagalog are present in a few counties, affecting five states (specifically, Alaska, Arizona, California, New Mexico, and Utah).⁴¹

To help plans and issuers meet the language requirements of paragraph (a)(5) of the 2012 final regulations, as requested by commenters, HHS has provided written translations of the SBC template, sample language, and the uniform glossary in Chinese, Navajo, Spanish, and Tagalog.⁴² HHS may also make these materials available in other languages to facilitate voluntary distribution of SBCs to other individuals with limited English proficiency. We seek comment on this standard, and on other potential standards that could facilitate consistency across the Departments' programs. The Departments anticipate that translations of the updated SBC template, sample language, and uniform glossary will be available when these proposed regulations are finalized.

Nothing in these proposed regulations should be construed as limiting an individual's rights under Federal or State civil rights statutes, such as Title VI of the Civil Rights Act of 1964 (Title VI) which prohibits recipients of Federal financial assistance, including issuers participating in Medicare Advantage, from discriminating on the basis of race, color, or national origin. To ensure non-discrimination on the basis of national origin, recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons. For more information,

⁴¹ Guidance on the HHS website contains a list of the counties that meet this threshold. This information is available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data_12-05-14_clean_508.pdf.

⁴² Translations are available at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html>.

see, “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,” available at

<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>.

B. Notice of Modification

PHS Act section 2715(d)(4) directs that a group health plan or health insurance issuer offering group or individual health insurance coverage must provide notice of any material modification (as defined under ERISA section 102) in any of the terms of the plan or coverage involved that is not reflected in the most recently provided SBC. For purposes of PHS Act section 2715, the 2012 final regulations interpret the statutory reference to the SBC to mean that only a material modification in the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage would trigger the notice. In these circumstances, the notice would be required to be provided to enrollees (or, in the individual market, covered individuals) no later than 60 days prior to the date on which such change will become effective. A material modification, within the meaning of section 102 of ERISA, includes any modification to the coverage offered under a plan or policy that, independently, or in conjunction with other contemporaneous modifications or changes, would be considered by an average plan participant (or in the case of individual market coverage, an average individual covered under a policy) to be an important change in covered benefits or other

terms of coverage under the plan or policy.⁴³ A material modification could be an enhancement of covered benefits or services or other more generous plan or policy terms. It includes, for example, coverage of previously excluded benefits or reduced cost-sharing. A material modification could also be a material reduction in covered services or benefits, as defined in 29 CFR 2520.104b-3(d)(3) of the Department of Labor's regulations, or more stringent requirements for receipt of benefits. As a result, it also includes changes or modifications that reduce or eliminate benefits, increase cost-sharing, or impose a new referral requirement.⁴⁴ (However, changes to the information in the SBC resulting from changes in the regulatory requirements for an SBC are not changes to the plan or policy requiring the mid-year provision of a notice of modification, unless specified in such new requirements.)

The 2012 final regulations require that this notice be provided only for changes other than in connection with a renewal or reissuance of coverage. At renewal, plans and issuers must provide an updated SBC in accordance with the requirements otherwise applicable to SBCs. PHS Act section 2715 and paragraph (b) of the 2012 final regulations specify the timing for providing a notice of modification in situations other than in connection with a renewal or reissuance of coverage. To the extent a plan or policy implements a mid-year change that is a material modification that affects the content of the SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the 2012 final regulations require a notice of modification to be provided 60

⁴³ See DOL Information Letter, Washington Star/Washington-Baltimore Newspaper Guild to Munford Page Hall, II, Baker & McKenzie (February 8, 1985).

⁴⁴ See, e.g., Ward v. Maloney, 386 F.Supp.2d 607, 612 (M.D.N.C. 2005), which discusses judicial interpretations of when an amendment is and is not a material modification.

days in advance of the effective date of the change.⁴⁵ Plans and issuers are permitted to either provide an updated SBC reflecting the modifications or provide a separate notice describing the material modifications. These proposed regulations do not make any changes to these requirements.

For ERISA-covered group health plans subject to PHS Act section 2715, this notice is required in advance of the timing requirements under the Department of Labor's regulations at 29 CFR 2520.104b-3 for providing a summary of material modification (SMM) (generally not later than 210 days after the close of the plan year in which the modification or change was adopted, or, in the case of a material reduction in covered services or benefits, not later than 60 days after the date of adoption of the modification or change). In situations where a complete notice is provided in a timely manner under PHS Act section 2715(d)(4), an ERISA-covered plan will also satisfy the requirement to provide an SMM under Part 1 of ERISA.

C. Requirement to Provide the Uniform Glossary

Sections 2715(g)(2) and (g)(3) of the PHS Act direct the Departments to develop standards for definitions, at a minimum, for certain insurance-related and medical terms (and also directs the Departments to develop standards for such other insurance-related and medical terms as will help consumers compare the terms of their coverage and the

⁴⁵ In Affordable Care Act Implementation FAQs Part XX, the Departments addressed notice requirements triggered by a closely-held for-profit corporation's health plan ceasing to provide coverage for some or all contraceptive services mid-plan year. The FAQ clarified that, for plans subject to ERISA that reduce or eliminate coverage of contraceptive services after having provided such coverage, expedited disclosure requirements for material reductions in covered services or benefits apply. See <http://www.dol.gov/ebsa/pdf/faq-aca20.pdf> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs20.html.

extent of medical benefits (or exceptions to those benefits)).⁴⁶ The 2012 final regulations included several additional terms in the uniform glossary.⁴⁷ As discussed later in this preamble, the Departments propose to revise definitions for several of these terms and also add several new terms to the Glossary.⁴⁸

A plan or issuer must make the uniform glossary available upon request within seven business days. To satisfy this requirement, a plan or issuer must provide the content described in paragraph (a)(2)(i)(L) of the 2012 final regulations, discussed earlier in this preamble, which requires that the SBC include 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 upon request. The Internet address may be a place where the document can be found on the plan's or issuer's website, or the website of either the Department of Labor or HHS. However, a plan or issuer must make the glossary available upon request, in either paper or electronic form (as requested), within seven business days after receipt of the request. Group health plans and health insurance issuers must provide the uniform glossary in the appearance specified by the Departments and without modification, so that the glossary is presented

⁴⁶ The insurance-related terms identified in the statute are: co-insurance, co-payment, deductible, excluded services, grievance and appeals, non-preferred provider, out-of-network co-payments, out-of-pocket limit, preferred provider, premium, and UCR (usual, customary and reasonable) fees. The medical terms identified in the statute are: durable medical equipment, emergency medical transportation, emergency room care, home health care, hospice services, hospital outpatient care, hospitalization, physician services, prescription drug coverage, rehabilitation services, and skilled nursing care.

⁴⁷ The additional terms in the uniform glossary issued with the 2012 final regulations are: allowed amount, balance billing, complications of pregnancy, emergency medical condition, emergency services, habilitation services, health insurance, in-network co-insurance, in-network co-payment, medically necessary, network, out-of-network co-insurance, plan, preauthorization, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, specialist, and urgent care.

⁴⁸ For further discussion of proposed changes to the Uniform Glossary, see section III later in this preamble.

in a uniform format and uses terminology understandable by the average plan enrollee or individual covered under an individual policy.

D. Preemption

Section 2715 of the PHS Act is incorporated into ERISA section 715, and Code section 9815, and is subject to the preemption provisions of ERISA section 731 and PHS Act section 2724 (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)). Under these provisions, the requirements of part 7 of ERISA and part A of title XXVII of the PHS Act, as amended by the Affordable Care Act, are not to be “construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement” of part A of title XXVII of the PHS Act. Accordingly, State laws that impose requirements on health insurance issuers that are stricter than those imposed by the Affordable Care Act will not be superseded by the Affordable Care Act. In addition, PHS Act section 2715(e) provides that the standards developed under PHS Act section 2715(a), “shall preempt any related State standards that require [an SBC] that provides less information to consumers than that required to be provided under this section, as determined by the [Departments].” Reading these two preemption provisions together, the 2012 final regulations do not, and these proposed regulations would not, prevent States from imposing separate, additional disclosure requirements on health insurance issuers.

E. Failure to Provide

PHS Act section 2715(f), incorporated into ERISA section 715 and Code section 9815, provides that a group health plan (including its administrator), and a health insurance issuer offering group or individual health insurance coverage, that “willfully fails to provide the information required under this section shall be subject to a fine of not more than \$1,000 for each such failure.” In addition, under PHS Act section 2715(f), a separate fine may be imposed for each individual or entity for whom there is a failure to provide an SBC. The 2012 final regulations addressed the different underlying enforcement structures and penalty mechanisms for the Departments.

HHS clarified in the 2012 final regulations that HHS will enforce these provisions in a manner consistent with 45 CFR 150.101 through 150.465. In these proposed regulations, the Department of Labor proposes to clarify that it will use the same process and procedures for assessment of the civil fine as used for failure to file an annual report under 29 CFR 2560.502c-2 and 29 CFR Part 2570, Subpart C. In accordance with ERISA section 502(b)(3), 29 U.S.C. 1132(b)(3), the Secretary of Labor is not authorized to assess this fine against a health insurance issuer. Moreover, in these proposed regulations, the IRS proposes to clarify that the IRS will enforce this section using a process and procedure consistent with section 4980D of the Code.

III. Proposed Documents authorized for plan years beginning on or after September 1, 2015

Contemporaneously with the issuance of these proposed regulations, the Departments are making available on their websites a proposed revised SBC template and attendant materials (including a proposed revised uniform glossary) to comply with the disclosure requirements of PHS Act section 2715. These materials are proposed to be

authorized by the Departments for disclosure provided in accordance with the applicability date proposed later in this preamble.⁴⁹ This section of the preamble describes the changes proposed to each document.

The following documents, available at <http://cciio.cms.gov> and www.dol.gov/ebsa/healthreform, are available for review and the Departments solicit comment on them:

1. SBC template. The document is available in accessible format (PDF) and modifiable format (MS Word).
2. Sample completed SBC. This document was completed using information for sample health coverage and provides a general illustration of a completed SBC for coverage under a group health plan.
3. Instructions. For assistance in completing the SBC template, separate instructions are available for group health coverage and for individual health insurance coverage. Additionally, with respect to the individual market instructions, the Office of Personnel Management (OPM) may provide additional instructions for Multi-State Plan issuers.
4. Why This Matters language. The SBC instructions include language that must be used when completing the "Why This Matters" column on the first page of the SBC template. Two language options are provided depending on whether the answer in the applicable row is "yes" or "no", according to the terms of the plan or coverage.

⁴⁹ See section IV of this preamble for a full discussion of the proposed applicability date.

5. Coverage examples. Information provided by HHS at <http://cciio.cms.gov> (and accessible via hyperlink from www.dol.gov/ebsa/healthreform) the information necessary to perform the coverage example calculations.
6. Uniform glossary. The uniform glossary of health coverage and medical terms may not be modified by plans or issuers.

Many of the changes proposed in the updated versions of these documents streamline the SBC. As discussed earlier in this preamble, these changes were made after feedback the Departments received from stakeholders, and the revised proposed template and other documents are intended to make it easier for plans to satisfy the statutory page limit. The revised documents also incorporate information from several sets of FAQs that addressed implementation of the SBC provisions.

Additionally, the revised documents include changes made to conform with new requirements that have become applicable since the issuance of the 2012 final regulations. These changes include the addition of information regarding minimum value and minimum essential coverage and changes to be consistent with the Affordable Care Act's requirement to eliminate all annual limits on essential health benefits.

Finally, the revised documents reflect changes to the coverage examples. The coding and pricing data for the existing coverage examples (having a baby through normal delivery and managing well controlled type 2 diabetes) have been updated to account for changes in the data since the issuance of the final regulations in 2012. Additionally the Departments proposed to change the data source for the claims and pricing information from a data source that used multiple commercial payor databases, to one based on a single database, the Truven Health Analytics MarketScan® Commercial

Claims and Encounters database, adjusted to estimate 2014 pricing to account for health care inflation since 2010. The Departments seek comment on whether to update this data using more recent 2013 Marketscan® database claims data that will be available for the final rule, and on appropriate ways to inform consumers of the resulting increases in sample care costs when the pricing data is updated, for example, through a cover letter or other disclosure provided along with the SBC. The Departments also seek specific comment on two diagnosis codes in the having a baby (normal delivery) scenario. The pricing data associated with these two codes, DRG 775 and DRG 795 (inpatient hospital charges for the mother, and inpatient hospital charges for the baby, respectively), appears higher than expected. These diagnosis codes represent bundled services and may include charges that are duplicated by other codes currently included in the scenario. The Departments seek comment on the accuracy of this pricing data.

Additionally, the SBC template, sample completed template, and coverage example documents have been updated to reflect that these proposed regulations would require a third coverage example – a simple foot fracture (with emergency room visit), as described earlier in this preamble. The same Marketscan® database has been used to produce the claim and pricing data for this scenario.

The Departments invite comment on all aspects of the proposed changes to the SBC template and other materials, and the uniform glossary. The Departments also request specific comments regarding the Instruction Guides about whether plans and issuers should be permitted to add additional benefits that are either covered or excluded in the “other covered services” and “excluded services” section that are not already required to be disclosed by the instructions.

IV. Applicability

After publication of the 2012 final regulations, the Departments received questions about the applicability of the SBC requirements to certain types of group health plans, including expatriate health plans, Medicare Advantage plans, and insurance products that are no longer being offered for purchase (closed blocks of business). The Departments addressed the applicability of the SBC requirements to each of these types of coverage in FAQs issued after publication of the 2012 final regulations. The Departments also received questions regarding the applicability of the SBC requirements to benefits provided under certain account-type arrangements such as health FSAs,⁵⁰ HRAs,⁵¹ and health savings accounts (HSAs),⁵² as well as benefits provided through an employee assistance program (EAP) and other excepted benefits.

In May 2012, the Departments issued FAQs that discussed the special circumstances and considerations faced by expatriate plans in complying with the SBC requirements.⁵³ The FAQs provided temporary relief from enforcement. Under recently enacted legislation,⁵⁴ expatriate health plans are not subject to the requirement to provide an SBC. The Departments intend to issue guidance implementing this legislation. The temporary relief from enforcement for expatriate plans will remain in place until such guidance is issued.

⁵⁰ See Code section 106(c)(2).

⁵¹ See IRS Notice 2002-45, 2002-2 C.B. 93.

⁵² See Code section 223.

⁵³ See Affordable Care Act Implementation FAQs Part IX, question 13, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

⁵⁴ See Consolidated and Further Continuing Appropriations Act, 2015, Division M, Expatriate Health Coverage Clarification Act of 2014, Section 3(d).

Moreover, in August 2012, the Departments issued FAQs that discussed group health plans providing Medicare Advantage benefits, which are Medicare benefits financed by the Medicare Trust Funds, for which the benefits are set by Congress and regulated by the Centers for Medicare & Medicaid Services. Again, the FAQs provided a temporary nonenforcement policy, because Medicare Advantage benefits are not health insurance coverage and Medicare Advantage organizations are not required to provide an SBC with respect to such benefits. Additionally, there are separately required disclosures required to be provided by Medicare Advantage organizations, to ensure that enrollees in these plans receive the necessary information about their coverage and benefits. These rules propose to exempt from the SBC requirements a group health plan benefit package that provides Medicare Advantage benefits.

The Departments also issued FAQs in May 2012 addressing insurance products that are no longer being offered for purchase (“closed blocks of business”). Some interested stakeholders had requested enforcement relief with respect to such products because the products are no longer offered for purchase and the SBC is intended to be a tool to help group health plans and individuals as they shop for coverage. The Departments had provided temporary relief through an FAQ provided that certain conditions were met: (1) the insurance product is no longer being actively marketed; (2) the health insurance issuer stopped actively marketing the product prior to September 23, 2012, when the requirement to provide an SBC was first applicable to health insurance issuers; and (3) the health insurance issuer has never provided an SBC with respect to

such product.⁵⁵ The Departments reiterate that relief here, but note that if an insurance product was actively marketed for business on or after September 23, 2012, and is no longer being actively marketed for business, or if the plan or issuer ever provided an SBC in connection with the product, the plan and issuer must provide the SBC with respect to such coverage, as required by PHS Act section 2715 and the regulations.

As under the 2012 final regulations, an SBC need not be provided for plans, policies, or benefit packages that constitute excepted benefits. Thus, for example, an SBC need not be provided for stand-alone dental or vision plans or health FSAs if they constitute excepted benefits under the Departments' regulations.⁵⁶ If benefits under a health FSA do not constitute excepted benefits, the health FSA is a group health plan generally subject to the SBC requirements. For a health FSA that does not meet the criteria for excepted benefits and that is integrated with other major medical coverage, the SBC is prepared for the other major medical coverage, and the effects of the health FSA can be denoted in the appropriate spaces on the SBC, including those for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. A stand-alone health FSA, which does not meet the criteria for excepted benefits, must satisfy the SBC requirements independently.

On October 1, 2014, the Departments published final rules on excepted benefits.⁵⁷ These regulations stated that an EAP constitutes excepted benefits if it satisfies certain

⁵⁵ See Affordable Care Act Implementation FAQs Part IX, question 12, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

⁵⁶ See 26 CFR 54.9831-1(c), 29 CFR 2590.732(c), 45 CFR 146.145(c).

⁵⁷ 79 FR 59130 (October 1, 2014).

requirements.⁵⁸ If an EAP qualifies as excepted benefits, the EAP need not separately satisfy the SBC requirements.

The Departments have issued guidance regarding HRAs since the publication of the 2012 final regulations.⁵⁹ An HRA is a group health plan. The Departments' guidance on HRAs clarifies that such arrangements are subject to the group market reform provisions of the Affordable Care Act, including the prohibition on annual limits under PHS Act section 2711 and the requirement to provide certain preventive services without cost sharing under PHS Act section 2713. The Departments' guidance further clarifies that such arrangements will not violate the market reform provisions when integrated with a group health plan that complies with those provisions (and that such arrangements cannot be integrated with individual market policies to satisfy the market reforms).

⁵⁸ The first requirement is that the EAP does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope, and duration of covered services are taken into account. (See preamble discussion at 79 FR 59133 for examples). The second requirement is that the EAP's benefits cannot be coordinated with the benefits under another group health plan. For this purpose, participants in the group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a "gatekeeper") before an individual is eligible for benefits under the other group health plan; and participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan. The third requirement is that no employee premiums or contributions may be required as a condition of participation in the EAP. The fourth requirement is that an EAP that constitutes excepted benefits may not impose any cost-sharing requirements.

⁵⁹ On September 13, 2013, DOL and the Treasury published guidance on the application of the market reforms and other provisions of the Affordable Care Act to health reimbursement arrangements (HRAs), certain health flexible spending arrangements (health FSAs) and certain other employer health care arrangements. See DOL Technical Release 2013-03, available at <http://www.dol.gov/ebsa/newsroom/tr13-03.html>, and IRS Notice 2013-54, available at <http://www.irs.gov/pub/irs-drop/n-13-54.pdf>. HHS also issued guidance to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in the DOL and Treasury Department guidance. See Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf>. On May 13, 2013, two FAQs were made available on the IRS website addressing employer healthcare arrangements, available at: www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements. On November 6, 2014, the Departments issued three FAQs on the compliance of premium reimbursement arrangements. See ACA Implementation FAQs Part XXII, available at <http://www.dol.gov/ebsa/pdf/faq-aca22.pdf> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs22.html.

Benefits under an HRA generally do not constitute excepted benefits, and thus HRAs are generally subject to the SBC requirements. An HRA integrated with other major medical coverage under a group health plan need not separately satisfy the SBC requirements; the SBC is prepared for the other major medical coverage, and the effects of employer allocations to an account under the HRA can be denoted in the appropriate spaces on the SBC, including those for deductibles, copayments, coinsurance, and benefits otherwise not covered by the other major medical coverage.

HSAs generally are not group health plans and thus generally are not subject to the SBC requirements. Nevertheless, an SBC prepared for a high deductible health plan associated with an HSA can (but is not required to) mention the effects of employer contributions to HSAs in the appropriate spaces on the SBC, including those for deductibles, copayments, coinsurance, and benefits otherwise not covered by the high deductible health plan.

V. Applicability Date

Changes to the current requirements to provide an SBC, notice of modification, and uniform glossary under PHS Act section 2715 and the 2012 final regulations are proposed to apply for disclosures with respect to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees) beginning on the first day of the first open enrollment period that begins on or after September 1, 2015. With respect to disclosures to participants and beneficiaries who enroll in group health coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the requirements of these proposed regulations are proposed to apply beginning on the

first day of the first plan year that begins on or after September 1, 2015. For disclosures to plans, and to individuals and dependents in the individual market, these requirements are proposed to apply to health insurance issuers beginning on September 1, 2015. We solicit comments on these proposed applicability dates.

VI. Economic Impact and Paperwork Burden

A. Executive Orders 12866 and 13563—Departments of Labor and HHS

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated a “significant regulatory action” under section 3(f) of Executive Order 12866.

Accordingly, the rule has been reviewed by the Office of Management and Budget.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year). As discussed below, the Departments have concluded that these proposed regulations would not have economic impacts of \$100 million or more in any one year or otherwise meet the definition of an “economically significant rule” under Executive Order 12866.

Nonetheless, consistent with Executive Orders 12866 and 13563, the Departments have provided an assessment of the potential benefits and the costs associated with this proposed regulation.

The primary benefits of these proposed regulations come from improved information, which will enable consumers, both individuals and employers, to better understand the health insurance coverage they have and provide, and make better coverage decisions based on their preferences with respect to benefit design, level of financial protection, and cost. The Departments believe that such improvements will result in a more efficient, competitive market. These proposed regulations will also benefit consumers by reducing the time they spend searching for and compiling health plan and coverage information.

The Departments have continued using the cost methodology that was used to estimate the costs presented in the 2012 final regulations. Since publication of the 2012 final regulations, the Departments have refined assumptions and estimates to incorporate better data. The estimates presented in these proposed regulations are a result of those efforts and represent the Departments' best estimates.

The primary cost of the proposed regulations is requiring issuers and plans to create a third coverage example, a simple foot fracture (with emergency room visit). This third coverage example will fit on the same page as the two existing coverage examples in the SBC template, so no new material costs are required by these proposed regulations. The quantified costs of these proposed regulations are for the actual production of the new coverage example.

These proposed regulations allow issuers and plans to continue to use the “Coverage Example Calculator.”⁶⁰ This calculator benefits issuers and plan sponsors by reducing the required time to produce the coverage examples. The calculator allows plans to either manually populate less than 20 data points on the plan’s design for one plan at a time, or to enter the data points for multiple plans at once. Most of the data fields needed for the new, proposed coverage example are already required to create the other two, already required coverage examples. While plan sponsors and issuers are not required to use the Coverage Example Calculator, the Departments expect that many will. Those choosing to perform the calculations without the calculator will make their own determination that it is more efficient and economically advantageous, or otherwise more appropriate for them to do so.

Using assumptions similar to those used in the regulatory impact analysis of the 2012 final regulations, with respect to plans and issuers that do not use the Coverage Example Calculator, the Departments estimate that large issuers and third-party administrators (TPAs), for all their plans and products, would spend a total of approximately 40 additional hours creating the new coverage example (30 hours for medium firms, and 20 hours for small firms). Once the new coverage example is completed, the Departments estimate that large firms would spend an estimated 25 hours in later years updating , while medium firms would spend 19 hours and small firms would spend 13 hours.

⁶⁰ <http://www.cms.gov/ccio/Resources/forms-reports-and-other-resources/index.html#sbcug>. For more information on the calculator , see section II.A.3 earlier in this preamble.

This leads to an estimated cost in the first year of \$3.4 million and for each subsequent year of \$2.1 million to produce the coverage example. Actual cost could be lower as firms organize their data in a manner that will allow them to use the automated functions of the Coverage Example Calculator. Tables 1 and 2 detail the calculations used to obtain the cost estimate for creating the new, proposed coverage example. The Paperwork Reduction Act section below contains a discussion of additional assumptions and data used to develop this estimate.

TABLE 1.-- *Year 1, Creating New Coverage Example*

	Type of Labor	Number of Firms	Hours Per Firm	Cost per Hour	Total Hour Burden	Equivalent Costs of Hours
Issuers						
Large	IT	75	22.0	\$84	1,650	\$138,584
	Benefits	75	16.0	\$62	1,200	\$74,796
	Legal	75	2.0	\$130	150	\$19,491
	Sub-Total				3,000	\$232,871
Medium	IT	250	16.5	\$84	4,125	\$346,459
	Benefits	250	12.0	\$62	3,000	\$186,990
	Legal	250	1.5	\$130	375	\$48,728
	Sub-Total				7,500	\$582,176
Small	IT	175	11.0	\$84	1,925	\$161,681
	Benefits	175	8.0	\$62	1,400	\$87,262
	Legal	175	1.0	\$130	175	\$22,740
	Sub-Total				3,500	\$271,682

TPAs

Large	IT	158	22.0	\$84	3,476	\$291,949
	Benefits	158	16.0	\$62	2,528	\$157,570
	Legal	158	2.0	\$130	316	\$41,061
Sub-Total					6,320	\$490,581
Medium	IT	526	16.5	\$84	8,679	\$728,949
	Benefits	526	12.0	\$62	6,312	\$393,427
	Legal	526	1.5	\$130	789	\$102,523
Sub-Total					15,780	\$1,224,899
Small	IT	368	11.0	\$84	4,048	\$339,992
	Benefits	368	8.0	\$62	2,944	\$183,500
	Legal	368	1.0	\$130	368	\$47,818
Sub-Total					7,360	\$571,309
Total					43,460	\$3,373,517

TABLE 2.-- Year 2, Creating New Coverage Example

Type of Labor		Number of Firms	Hours Per Firm	Cost per Hour	Total Hour Burden	Equivalent Costs of Hours
Issuers						
Large	IT	75	13.8	\$84	1,031	\$86,615
	Benefits	75	10.0	\$62	750	\$46,748
	Legal	75	1.3	\$130	94	\$12,182
Sub-Total					1,875	\$145,544
Medium	IT	250	10.3	\$84	2,578	\$216,537
	Benefits	250	7.5	\$62	1,875	\$116,869

	Legal	250	0.9	\$130	234	\$30,455
	Sub-Total				4,688	\$363,860
Small	IT	175	6.9	\$84	1,203	\$101,050
	Benefits	175	5.0	\$62	875	\$54,539
	Legal	175	0.6	\$130	109	\$14,212
	Sub-Total				2,188	\$169,801
TPAs						
Large	IT	158	13.8	\$84	2,173	\$182,468
	Benefits	158	10.0	\$62	1,580	\$98,481
	Legal	158	1.3	\$130	198	\$25,663
	Sub-Total				3,950	\$306,613
Medium	IT	526	10.3	\$84	5,424	\$455,593
	Benefits	526	7.5	\$62	3,945	\$245,892
	Legal	526	0.9	\$130	493	\$64,077
	Sub-Total				9,863	\$765,562
Small	IT	368	6.9	\$84	2,530	\$212,495
	Benefits	368	5.0	\$62	1,840	\$114,687
	Legal	368	0.6	\$130	230	\$29,886
	Sub-Total				4,600	\$357,068
Total					27,163	\$2,108,448

B. Paperwork Reduction Act

1. Department of Labor and Department of the Treasury

To implement PHS Act section 2715 and these proposed regulations, collection of information requirements relate to the provision of the following:

- Summary of benefits and coverage.
- Coverage examples (as components of each SBC).
- A uniform glossary of health coverage and medical terms (uniform glossary).
- Notice of modifications.

A copy of the information collection request (ICR) may be obtained by contacting the PRA addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Room N-5718, Washington, DC 20210. Telephone: (202) 693-8410; Fax: (202) 219-4745. These are not toll-free numbers. E-mail: ebssa.opr@dol.gov. ICRs submitted to OMB also are available at [reginfo.gov](http://www.reginfo.gov/public/do/PRAMain) (<http://www.reginfo.gov/public/do/PRAMain>).

This analysis includes the coverage examples that are part of the SBC disclosure, therefore, the Departments calculate a single burden estimate for purposes of this section, assuming the information collection request for the SBC (including coverage examples) totals eight (8) sides of a page in length.

The Departments assume fully-insured ERISA plans will rely on health insurance issuers and self-insured plans will rely on TPAs to perform these functions. While self-insured plans may prepare SBCs internally, the Departments make this simplifying assumption because most plans appear to rely on issuers and TPAs for the purpose of administrative duties, such as enrollment and claims processing. Thus, the Departments use health insurance issuers and TPAs as the unit of analysis for the purposes of estimating administrative costs.

The Departments estimate there are a total of 500 issuers and 1,050 TPAs affected by this information collection.⁶¹ Because HHS shares the hour and cost burden for fully-insured plans with the Departments of Labor and the Treasury, HHS assumes 50 percent of the hour and cost burden estimates to account for burden for issuers in the individual market and 15 percent of the burden for TPAs to account for those TPAs serving self-insured non-Federal governmental plans. The Departments of Labor and the Treasury assume the other 50 percent of the burden related to issuers to account for burden servicing fully insured ERISA plans, and 85 percent of the burden related to TPAs to account for the burden related to ERISA self-insured plans.

To account for variation in costs due to firm size and the number of plans and individuals they service, the Departments divide issuers into small, medium, and large categories.⁶² Accordingly, the Departments estimate that there are approximately 175 small, 250 medium, and 75 large issuers. The Departments lack information to create a similar split for TPAs, so they assume a similar distribution resulting in an estimate of approximately 368 small, 526 medium, and 158 large TPAs.

The estimated hour burden and equivalent cost for the collections of information are as follows: The Departments estimate an administrative burden on issuers and TPAs to make appropriate changes to IT systems and processes and make updates to the SBCs

⁶¹ The estimate for the number of issuers is based on the number of issuers for the group and individual market filing with HHS for the Medical Loss Ratio regulations. See 45 CFR Part 158. The number of TPAs is based on the U.S. Census's 2011 Statistics of U.S. Businesses that reports there are 3,157 TPA's. Previous discussions with industry experts led to assuming about one-third of the TPA's (1,052) could be providing services to self-insured plans.

⁶² The Departments define small issuers as those with total earned premiums less than \$50 million; medium issuers as those with total earned premiums between \$50 million and \$999 million; and large issuers as those with total earned premiums of \$1 billion or more. The premium revenue data come from the 2009 NAIC financial statements, also known as "Blanks," where insurers report information about their various lines of business.

and coverage examples. The Departments estimate that large firms would spend 190 hours (40 hours of which would be new due to the proposed regulation) in the first year, medium firms would spend 75 percent of large firm hour burden, and small firms would spend 50 percent of the large firm hour burden to perform these tasks. The total burden would be split among IT professionals (55 percent), benefits professionals (40 percent), and legal professionals (5 percent), with hourly labor rates of \$83.99, \$62.33, and \$129.94 respectively.⁶³ Clerical labor rates are \$30.42 per hour.

Tables 3 (first year) and 4 (subsequent years) show the calculations used to obtain the hours burden of 153,600 hours (first year) and 141,600 hours (subsequent years) and the equivalent cost burden of \$11.9 million (first year) and \$11.0 million (subsequent years) for issuers and TPAs to prepare the SBCs and coverage examples. In addition, clerical employees would spend 653,000 hours with an equivalent cost of \$19.8 million in each year preparing and distributing the SBCs.

Based on the foregoing , the total hours burden for this information collection would be 806,000 hours for the first year (794,000 hours for subsequent years) with an

⁶³ The Departments' estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/pdf/ocwage.pdf>); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/ecec.t02.htm>); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 <http://www.bls.gov/news.release/eci.nr0.htm>). Computer Systems Analysts (15-1121): \$41.02(2013 BLS Wage rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 years from base year) = \$83.99; Compensation, benefits, and job analysis specialists (13-1141): \$30.44(2013 BLS Wage rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 years from base year) = \$62.33; Legal Professional (23-1011): \$63.46(2013 BLS Wage rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 years from base year) = \$129.94; Secretaries, Except Legal, Medical, and Executive (43-6014): \$16.35(2013 BLS Wage rate)/0.675(ECEC ratio) *1.2(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 year) = \$30.42.

equivalent cost of \$31.7 million for the first year (\$30.8 million for subsequent years).

This burden is split evenly between the Departments of Labor and the Treasury.

TABLE 3.--Update SBC including Coverage Examples, Year 1

Type of Labor		Number of Firms	Hours Per Firm	Cost per Hour	Total Hour Burden	Total Cost Burden
Issuers						
Large	IT	75	52.3	\$84	3,919	\$329,136
	Benefits	75	38.0	\$62	2,850	\$177,641
	Legal	75	4.8	\$130	356	\$46,291
Sub-Total					7,125	\$553,067
Medium	IT	250	39.9	\$84	9,969	\$837,275
	Benefits	250	29.0	\$62	7,250	\$451,893
	Legal	250	3.6	\$130	906	\$117,758
Sub-Total					18,125	\$1,406,926
Small	IT	175	26.1	\$84	4,572	\$383,992
	Benefits	175	19.0	\$62	3,325	\$207,247
	Legal	175	2.4	\$130	416	\$54,006
Sub-Total					8,313	\$645,245
TPAs						
Large	IT	158	88.8	\$84	14,034	\$1,178,745
	Benefits	158	64.6	\$62	10,207	\$636,190
	Legal	158	8.1	\$130	1,276	\$165,784
Sub-Total					25,517	\$1,980,719
Medium	IT	526	67.8	\$84	35,656	\$2,994,766

	Benefits	526	49.3	\$62	25,932	\$1,616,329
	Legal	526	6.2	\$130	3,241	\$421,197
Sub-Total					64,830	\$5,032,293
Small	IT	368	44.4	\$84	16,344	\$1,372,716
	Benefits	368	32.3	\$62	11,886	\$740,879
	Legal	368	4.0	\$130	1,486	\$193,065
Sub-Total					29,716	\$2,306,660
Total					153,625	\$11,924,910

TABLE 4.-- Update SBC including Coverage Examples, Subsequent Years

	Type of Labor	Number of Firms	Hours Per Firm	Cost per Hour	Total Hour Burden	Total Cost Burden
Issuers						
Large	IT	75	48.1	\$84	3,609	\$303,151
	Benefits	75	35.0	\$62	2,625	\$163,616
	Legal	75	4.4	\$130	328	\$42,637
Sub-Total					6,563	\$509,404
Medium	IT	250	36.8	\$84	9,195	\$772,314
	Benefits	250	26.8	\$62	6,688	\$416,832
	Legal	250	3.3	\$130	836	\$108,622
Sub-Total					16,719	\$1,297,768
Small	IT	175	24.1	\$84	4,211	\$353,677
	Benefits	175	17.5	\$62	3,063	\$190,886
	Legal	175	2.2	\$130	383	\$49,743
Sub-Total					7,656	\$594,305
TPAs						
Large	IT	158	81.8	\$84	12,926	\$1,085,686
	Benefits	158	59.5	\$62	9,401	\$585,964
	Legal	158	7.4	\$130	1,175	\$152,696
Sub-Total					23,503	\$1,824,346

Medium	IT	526	62.5	\$84	32,890	\$2,762,414
	Benefits	526	45.5	\$62	23,920	\$1,490,924
	Legal	526	5.7	\$130	2,990	\$388,518
Sub-Total					59,800	\$4,641,856
Small	IT	368	40.9	\$84	15,054	\$1,264,343
	Benefits	368	29.8	\$62	10,948	\$682,389
	Legal	368	3.7	\$130	1,369	\$177,823
Sub-Total					27,370	\$2,124,555
Total					141,610	\$10,992,235

The Departments also estimate the cost burden associated with the SBC, Uniform Glossary and Notice of Modification. These costs are discussed below.

- SBC**-The Departments estimate that approximately 60.6 million SBCs will be delivered with 527,000 going to ERISA plans and 60.1 million going to participants and beneficiaries annually.⁶⁴ The Departments assume 50 percent of the SBCs going to plans would be sent electronically while 38 percent of SBCs would be sent electronically to plan participants. Accordingly, the Departments estimate that about 23.4 million SBCs would be distributed electronically and about 37.2 million SBCs would be distributed on paper. The Departments assume there are costs only for paper disclosures, with de minimis costs for electronic disclosures. The SBC, with coverage examples, is assumed to be four double-sided pages (eight page sides) in length. Paper SBCs sent to participants would have no postage costs as they could be included in mailings with other plan materials, however all notices sent to beneficiaries living apart from the participant

⁶⁴ Based on the 2012 Current Population Survey the Department estimates there are 58.0 million policy holders in ERISA plans <http://www.dol.gov/ebsa/pdf/coveragebulletin2013.pdf> table 2.

would be mailed and have a 49 cent postage costs. Printing costs would be five cents per page. Each document sent by mail would have a one minute preparation burden, with the task performed by a clerical worker. Based on the foregoing, the total cost burden to prepare and distribute the SBC would be \$16.4 million.

- **Uniform Glossary** – The Departments assume that 2.5 percent of those who receive paper SBCs will request glossaries in paper form (that is, about 1.1 million glossary requests). The total cost burden to prepare and distribute paper copies of the Uniform Glossaries would be \$760,000.
- **Notice of Modifications** – The Departments assume that issuers and plans will send notices of modification to covered participants and beneficiaries, and that 2 percent of covered participants and beneficiaries will receive such notices (1.2 million notices). As with the SBC, 50 percent of plans and 38 percent of policy holders will receive electronic notices. Paper notices are assumed to be of the same length as an SBC, and will incur a postage cost of 49 cents. The total cost burden to prepare and distribute the notices of modification would be \$640,000.

Based on the foregoing, the total annual cost burden is estimated to be \$16.4 million.

This burden is split evenly between the Departments of Labor and the Treasury.

TABLE 5 -- Preparation and Distribution Costs: Cost Burden

	Number of Disclosures	Number of Disclosures Sent on Paper	Material and Printing Costs	Postage Costs	Total Cost Burden
<i>SBC with Coverage Examples to Group Health Plan</i>					
Renewal or Application	527,328	263,664	\$105,466	\$0	\$105,466
Sub-Total	527,328	263,664	\$105,466	\$0	\$105,466

SBC with Coverage Examples To Participants and Beneficiaries

Upon Application or Eligibility	2,030,000	1,015,000	\$406,000	\$0	\$406,000
Upon Renewal	58,000,000	35,960,000	\$14,384,000	\$0	\$14,384,000
Beneficiaries Living Apart	90,000	90,000	\$36,000	\$44,100	\$80,100
Sub-Total	60,120,000	36,975,000	\$14,826,000	\$44,100	\$14,870,100
<i>Uniform Glossary</i>	1,102,000	1,102,000	\$220,400	\$539,980	\$760,380
<i>Notice of Modification</i>	1,160,000	719,200	\$287,680	\$352,408	\$640,088
Total	62,909,328	39,059,864	\$15,439,546	\$936,488	\$16,376,034

TABLE 6 -- Preparation and Distribution Costs: Hour Burden

	Number of Disclosures	Number of Disclosures Sent on Paper	Clerical Hours	Clerical Costs	Total Hour Burden	Total Equivalent Cost
<i>SBC with Coverage Examples to Group Health Plan</i>						
Renewal or Application	527,328	263,664	4,394	\$130,074	4,394	\$130,074
Sub-Total	527,328	263,664	4,394	\$130,074	4,394	\$130,074
<i>SBC with Coverage Examples To Participants and Beneficiaries</i>						
Upon Application or Eligibility	2,030,000	1,015,000	16,917	\$500,733	16,917	\$500,733
Upon Renewal	58,000,000	35,960,000	599,333	\$17,740,267	599,333	\$17,740,267
Beneficiaries Living Apart	90,000	90,000	1,500	\$44,400	1,500	\$44,400
Sub-Total	60,120,000	36,975,000	617,750	\$18,285,400	617,750	\$18,285,400
<i>Uniform Glossary</i>	1,102,000	1,102,000	18,367	\$543,653	18,367	\$543,653
<i>Notice of Modification</i>	1,160,000	719,200	11,987	\$354,805	11,987	\$354,805
Total	62,909,328	39,059,864	652,498	\$19,313,933	652,498	\$19,313,933

The Departments note that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a

valid OMB control number. The 2015-2017 paperwork burden estimates are summarized as follows:

Type of Review:

Agencies: Employee Benefits Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of the Treasury.

Title: Affordable Care Act Uniform Explanation of Coverage Documents

OMB Number: 1210-0147; 1545–2229.

Affected Public: Business or other for profit; not-for-profit institutions.

Total Respondents: 2,389,000

Total Responses: 62,909,000

Frequency of Response: On-going.

Estimated Total Annual Burden Hours (three year average): 399,000 hours (Employee Benefits Security Administration); 399,000 hours (Internal Revenue Service).

Estimated Total Annual Cost Burden (three year average): \$8,188,000 (Employee Benefits Security Administration); \$8,188,000 (Internal Revenue Service).

2. Department of Health and Human Services

The Paperwork Reduction Act (PRA) section for the Departments of Labor and the Treasury above contain the assumptions, data sources, and explanations of the Departments’ methodology for estimating the PRA burden. The following tables summarize the Department of Health and Human Services’ burden estimates.

TABLE 7 -- Update SBC including Coverage Examples; Year 1

Type of Labor	Number of Firms	Hours Per Firm	Cost per Hour	Total Hour Burden	Equivalent Costs
<i>Issuers</i>					

Large	IT	75	52.3	\$84	3,919	\$329,136
	Benefits	75	38.0	\$62	2,850	\$177,641
	Legal	75	4.8	\$130	356	\$46,291
Sub-Total					7,125	\$553,067
Medium	IT	250	39.9	\$84	9,969	\$837,275
	Benefits	250	29.0	\$62	7,250	\$451,893
	Legal	250	3.6	\$130	906	\$117,758
Sub-Total					18,125	\$1,406,926
Small	IT	175	26.1	\$84	4,572	\$383,992
	Benefits	175	19.0	\$62	3,325	\$207,247
	Legal	175	2.4	\$130	416	\$54,006
Sub-Total					8,313	\$645,245
<i>TPAs</i>						
Large	IT	158	15.7	\$84	2,477	\$208,014
	Benefits	158	11.4	\$62	1,801	\$112,269
	Legal	158	1.4	\$130	225	\$29,256
Sub-Total					4,503	\$349,539
Medium	IT	526	12.0	\$84	6,292	\$528,488
	Benefits	526	8.7	\$62	4,576	\$285,235
	Legal	526	1.1	\$130	572	\$74,329
Sub-Total					11,441	\$888,052
Small	IT	368	7.8	\$84	2,884	\$242,244
	Benefits	368	5.7	\$62	2,098	\$130,743

Legal	368	0.7	\$130	262	\$34,070
Sub-Total				5,244	\$407,058
Total				54,750	\$4,249,887

TABLE 8-- Update SBC including Coverage Examples, Subsequent Years

	Type of Labor	Number of Firms	Hours Per Firm	Cost per Hour	Total Hour Burden	Equivalent Costs
<i>Issuers</i>						
Large	IT	75	48.1	\$84	3,609	\$303,151
	Benefits	75	35.0	\$62	2,625	\$163,616
	Legal	75	4.4	\$130	328	\$42,637
Sub-Total					6,563	\$509,404
Medium	IT	250	36.8	\$84	9,195	\$772,314
	Benefits	250	26.8	\$62	6,688	\$416,832
	Legal	250	3.3	\$130	836	\$108,622
Sub-Total					16,719	\$1,297,768
Small	IT	175	24.1	\$84	4,211	\$353,677
	Benefits	175	17.5	\$62	3,063	\$190,886
	Legal	175	2.2	\$130	383	\$49,743
Sub-Total					7,656	\$594,305
<i>TPAs</i>						
Large	IT	158	14.4	\$84	2,281	\$191,592
	Benefits	158	10.5	\$62	1,659	\$103,405
	Legal	158	1.3	\$130	207	\$26,946
Sub-Total					4,148	\$321,943
Medium	IT	526	11.0	\$84	5,804	\$487,485
	Benefits	526	8.0	\$62	4,221	\$263,104
	Legal	526	1.0	\$130	528	\$68,562
Sub-Total					10,553	\$819,151
Small	IT	368	7.2	\$84	2,657	\$223,119
	Benefits	368	5.3	\$62	1,932	\$120,422

Legal	368	0.7	\$130	242	\$31,381
Sub-Total				4,830	\$374,922
Total				50,468	\$3,917,493

TABLE 9-- Preparation and Distribution Costs

	Number of Disclosures	Number of Disclosures Sent on Paper	Clerical Hour Burden	Total Equivalent Cost
<i>Group Health Plan</i>				
<i>SBC with Coverage Examples</i>	15,750	7,875	131.25	\$3,885
<i>SBC with Coverage Examples- Participants and Beneficiaries</i>				
Upon Application or Eligibility	222,680	111,340	1,855.67	\$54,928
Upon Renewal	17,129,262	8,564,631	142,743.85	\$4,225,218
Beneficiaries Living Apart	33,000	33,000	550.00	\$16,280
Sub-Total	17,384,942	8,708,971	145,150	\$4,296,426
Uniform Glossary	428,232	428,232	7,137	\$211,261
Notice of Modification	342,585	171,293	2,855	\$84,504
<i>Individual Market</i>				
<i>SBC with Coverage Examples</i>	21,784,217	6,535,265	108,921	\$3,224,064
<i>Uniform Glossary</i>	762,448	762,448	12,707	\$376,141
<i>Notice of Modification</i>	435,684.34	130,705	2,178	\$64,481
Total	41,153,858	16,744,788	279,080	\$8,260,762

TABLE 10 -- Preparation and Distribution Costs

	Number of Disclosures	Number of Disclosures Sent on Paper	Material and Printing Costs	Postage Costs	Total Cost Burden
<i>Group Health Plan</i>					
<i>SBC with Coverage Examples</i>	15,750	7,875	\$3,150		\$3,150
<i>SBC with Coverage Examples- Participants and Beneficiaries</i>					
Upon Application or Eligibility	222,680	111,340	\$44,536		\$44,536
Upon Renewal	17,129,262	8,564,631	\$3,425,852		\$3,425,852

Beneficiaries Living Apart	33,000	33,000	\$13,200	\$16,170	\$29,370
Sub-Total	17,384,942	8,708,971	\$3,483,588	\$16,170	\$3,499,758
Uniform Glossary	428,232	428,232	\$85,646	\$209,833	\$295,480
Notice of Modification	342,585	171,293	\$68,517	\$83,933	\$152,450
<i>Individual Market</i>					
<i>SBC with Coverage Examples</i>	21,784,217	6,535,265	\$2,614,106		\$2,614,106
<i>Uniform Glossary</i>	762,448	762,448	\$152,490	\$373,599	\$526,089
<i>Notice of Modification</i>	435,684.34	130,705	\$52,282	\$64,046	\$116,328
Total	41,153,858	16,744,788	\$6,459,780	\$747,582	\$7,207,361

HHS is proposing that issuers be required to make available on an Internet web address a copy of the actual individual coverage policy or group certificate of coverage.⁶⁵ HHS estimates that the burden of this request will be de minimis because the documents will have already been created and issuers already have web addresses on which the materials can be made available.

The Department notes that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number.

The 2015-2017 paperwork burden estimates are summarized as follows:

Type of Review: *Revision.*

Agency: Department of Health and Human Services.

Title: Summary of benefits and Coverage Uniform Glossary

CMS Identifier (OMB Control Number): CMS-10407 (0938-1146).

Affected Public: State, Local, or Tribal Governments.

⁶⁵ See proposed 45 CFR 147.200(a)(2)(i)(J).

Total Respondents: 126,500.

Total Responses: 41,154,000.

Frequency of Response: On-going.

Estimated Total Annual Burden Hours (three year average): 331,000 hours.

Estimated Total Annual Cost Burden (three year average): \$7,207,000

ICRs Related to Deemed Compliance Reporting (45 CFR 147.200(a)(4)(iii)(C))

Under 45 CFR 147.200(a)(4)(iii)(C), if individual health insurance issuers provide the content required for the SBC to the federal health reform Web portal described in 45 CFR 159.120 (HealthCare.gov), then they will be deemed to have satisfied the requirement to provide an SBC to individuals who request information about coverage prior to submitting an application for coverage. Individual health insurance issuers already provide most SBC content elements to HealthCare.gov, except for five data elements related to patient responsibility for each coverage example: deductibles, co-payments, co-insurance, coverage limits or exclusions, and the total out-of-pocket cost to the enrollee in view of these cost-sharing amounts and coverage limits or exclusions.

Accordingly, the additional burden associated with the requirements under §147.200(a)(4)(iii)(C) is the time and effort it would take each of the 320 issuers submitting this data in the individual market to enter the five additional data elements into an Excel spreadsheet. We estimate that it will take these issuers about 160 hours, at a total estimated cost of about \$4,800, for each coverage example. For three coverage examples, the burden and cost would be about 480 hours at a cost of about \$14,400.

In deriving these figures, we used the following hourly labor rates and estimated the time to complete each task: \$ 30.78/hr. and 0.5 hr./issuer for clerical staff to enter data into an Excel spreadsheet, or about \$15 per respondent per coverage example.

This information collection requirement reflects the requirement that issuers must provide all content required in the SBC, including the information necessary for coverage examples, to HealthCare.gov to be deemed compliant. The aforementioned burden estimates will be submitted for OMB review and approval as a revision to the information collection request currently approved under OMB control number 0938-1086.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site at <http://www.cms.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage> or email your request, including your address, phone number, OMB control number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office at 410-786-1326.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and which are likely to have a significant economic impact on a substantial number of small entities. Unless the head of an agency certifies that a proposed rule is not likely to have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires that the agency present an initial regulatory flexibility analysis

(IRFA) describing the rule’s impact on small entities and explaining how the agency made its decisions with respect to the application of the rule to small entities.

The RFA generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. (States and individuals are not included in the definition of “small entity.”)

There are several different types of small entities affected by these proposed regulations. For issuers and TPAs, the Departments use as their measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent. For plans, the Departments continue to consider a small plan to be an employee benefit plan with fewer than 100 participants.⁶⁶ Further, while some large employers may have small plans, in general small employers maintain most small plans. Thus, the Departments believe that assessing the impact of this proposed rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.). The Departments therefore request comments on the appropriateness of the size standard used in evaluating the impact of these proposed regulations on small entities.

⁶⁶ The basis for this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans that cover fewer than 100 participants.

The Departments carefully considered the likely impact of the rule on small entities in connection with their assessment under Executive Order 12866. The Departments believe that the proposed regulations include flexibility like allowing use of the Coverage Example Calculator that would minimize the burden on small entities. Also, the Departments believe that the burden imposed by the proposed regulation on small insurers and small TPAs will be 20 hours or less annually.

The Departments hereby certify that these proposed regulations will not have a significant economic impact on a substantial number of small entities, as described above. Consistent with the policy of the RFA, the Departments encourage the public to submit comments that would allow the Departments to assess the impacts specifically on small entities or suggest alternative rules that accomplish the stated purpose of PHS Act section 2715 and minimize the impact on small entities.

D. Unfunded Mandates Reform Act--Department of Labor and Department of Health and Human Services

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any proposed rule that includes a Federal mandate that could result in expenditure in any one year by State, local or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars updated annually for inflation. In 2014, that threshold level is approximately \$141 million. These proposed regulations include no mandates on State, local, or Tribal governments. These proposed regulations propose requirements regarding standardized consumer disclosures that would affect private sector firms (for example, health insurance issuers offering coverage in the individual and group markets, and third-party

administrators providing administrative services to group health plans), but we conclude that these costs would not exceed the \$141 million threshold. Thus, the Departments of Labor and HHS conclude that these proposed regulations would not impose an unfunded mandate on State, local or Tribal governments or the private sector. Regardless, consistent with policy embodied in UMRA, the proposed requirements described in this notice of proposed rulemaking has been designed to be the least burdensome alternative for State, local and Tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

E. Federalism Statement--Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have "substantial direct effects" on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have federalism implications must consult with State and local officials and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments of Labor's and HHS' view, these proposed rules have federalism implications because they would have direct effects on the States, the relationship between national governments and States, or on the distribution of power and responsibilities among various levels of government relating to the disclosure of health insurance coverage information to consumers. Under these proposed rules, all group

health plans and health insurance issuers offering group or individual health insurance coverage, including self-funded non-federal governmental plans as defined in section 2791 of the PHS Act, would be required to follow uniform standards for compiling and providing a summary of benefits and coverage to consumers. Such Federal standards developed under PHS Act section 2715(a) would preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under PHS Act section 2715(a).

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be “construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement” of a Federal standard. The conference report accompanying HIPAA indicates that this is intended to be the “narrowest” preemption of State laws (See House Conf. Rep. No. 104-736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018).

States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the

subject of this rulemaking. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law. However, under these proposed rules, a State would not be allowed to impose a requirement that modifies the summary of benefits and coverage required to be provided under PHS Act section 2715(a), because it would prevent the application of this proposed rule's uniform disclosure requirement.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments of Labor and HHS have engaged in efforts to consult with and work cooperatively with affected States, including consulting with, and attending conferences of, the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis. It is expected that the Departments of Labor and HHS will act in a similar fashion in enforcing the Affordable Care Act, including the provisions of section 2715 of the PHS Act. Throughout the process of developing these proposed regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, the Departments of Labor and HHS have attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments of Labor's and HHS' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this proposed rule, the Departments certify that the

Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached proposed rule in a meaningful and timely manner.

F. Special Analyses – Department of the Treasury

For purposes of the Department of the Treasury it has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these proposed regulations. For a discussion of the impact of this proposed rule on small entities, please see section V.C. of this preamble. Pursuant to section 7805(f) of the Code, this notice of proposed rulemaking has been submitted to the Small Business Administration for comment on its impact on small business.

G. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

VII. Statutory Authority

The Department of the Treasury regulations are proposed to be adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are proposed to be adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161-1168, 1169, 1181-1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104-191, 110 Stat. 1936; sec. 401(b), Pub. L. 105-200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110-343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111-148, 124 Stat. 119, as amended by Pub. L. 111-152, 124 Stat. 1029; Secretary of Labor's Order 1-2011, 77 FR 1088 (January 9, 2012).

The Department of Health and Human Services regulations are proposed to be adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

John M. Dalrymple
Deputy Commissioner for Services and Enforcement,
Internal Revenue Service.

Signed this 19th day of December, 2014

Signed this 18th day of December, 2014.

Phyllis C. Borzi
Assistant Secretary
Employee Benefits Security Administration
Department of Labor

CMS-9938-P

Dated: December 18, 2014

Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: December 19, 2014

Sylvia Burwell,

Secretary,

Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Chapter 1

Accordingly, 26 CFR Part 54 is proposed to be amended as follows:

PART 54 —PENSION EXCISE TAXES

Paragraph 1. The authority citation for Part 54 continues to read in part as follows:

Authority: Authority: 26 U.S.C. 7805. * * *

Section 54.9815-2715 also issued under 26 U.S.C. 9833.

Paragraph 2. Section 54.9815-2715 is revised to read as follows:

§ 54.9815-2715 Summary of benefits and coverage and uniform glossary.

(a) Summary of benefits and coverage– (1) In general. A group health plan (and its administrator as defined in section 3(16)(A) of the Employee Retirement Income Security Act of 1974 (ERISA)), and a health insurance issuer offering group health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

(i) SBC provided by a group health insurance issuer to a group health plan – (A) Upon application. A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application for health coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. If an SBC was provided before application pursuant to paragraph (a)(1)(i)(D) of this section (relating to SBCs upon request), this paragraph (a)(1)(i)(A) is deemed satisfied, provided there is no change

to the information required to be in the SBC. However, if there has been a change in the information required, a new SBC that includes the correct information must be provided upon application pursuant to this paragraph (a)(1)(i)(A).

(B) By first day of coverage (if there are 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 issuer must update and provide a current SBC to the plan (or its sponsor) no later than the first day of coverage.

(C) Upon renewal, reissuance, or re-enrollment. If the issuer renews or reissues a policy, certificate, or contract of insurance for a succeeding policy year, or automatically re-enrolls the policyholder or its participants and beneficiaries in coverage, the issuer must provide a new SBC as follows:

(1) If written application is required (in either paper or electronic form) for renewal or reissuance, the SBC must be provided no later than the date the written application materials are distributed.

(2) If renewal, reissuance, or re-enrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, 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.

(D) Upon request. If a group health plan (or its sponsor) requests an SBC or summary information about a health insurance product from a health insurance issuer

offering group health insurance coverage, an SBC must be provided as soon as practicable, but in no event later than seven business days following receipt of the request.

(ii) SBC provided by a group health insurance issuer and a group health plan to participants and beneficiaries – (A) In general. A group health plan (including its administrator, as defined under section 3(16) of ERISA), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary (as defined under sections 3(7) and 3(8) of ERISA), and consistent with the rules of paragraph (a)(1)(iii) of this section, with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.

(B) Upon application. 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, the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage for the participant or any beneficiaries. If an SBC was provided before application pursuant to paragraph (a)(1)(ii)(F) of this section (relating to SBCs upon request), this paragraph (a)(1)(ii)(B) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information content, a new SBC that includes the correct information must be provided upon application pursuant to this paragraph (a)(1)(ii)(B).

(C) By first day of coverage (if there are changes). If there is any change to 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 to a participant or beneficiary no later than the first day of coverage.

(D) Special enrollees. The plan or issuer must provide the SBC to special enrollees (as described in § 54.9801-6) no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is 90 days from enrollment.

(E) Upon renewal, reissuance, or re-enrollment. If the plan or issuer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), or automatically re-enrolls participants and beneficiaries in coverage, the plan or issuer must provide a new SBC, as follows:

(1) If written application is required for renewal, reissuance, or re-enrollment (in either paper or electronic form), the SBC must be provided no later than the date on which the written application materials are distributed.

(2) If renewal, reissuance, or re-enrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, 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.

(F) Upon request. A plan or issuer must provide the SBC to participants or beneficiaries 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.

(iii) Special rules to prevent unnecessary duplication with respect to group health coverage – (A) An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with the other rules of this section. Therefore, for example, in the case of a group health plan funded through an insurance policy, the plan satisfies the requirement to provide an SBC with respect to an individual if the issuer provides a timely and complete SBC to the individual. An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual that contracts with another party to provide such SBC is considered to satisfy the requirement to provide such SBC if:

(1) The entity monitors performance under the contract;

(2) If the entity has knowledge that the SBC is not being provided in a manner that satisfies the requirements of this section and the entity has all information necessary to correct the noncompliance, the entity corrects the noncompliance as soon as practicable; and

(3) If the entity has knowledge the SBC is not being provided in a manner that satisfies the requirements of this section and the entity does not have all information necessary to correct the noncompliance, the entity communicates with participants and beneficiaries who are affected by the noncompliance regarding the noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

(B) If a single SBC is provided to a participant and any beneficiaries at the participant's last known address, then the requirement to provide the SBC to the participant and any beneficiaries is generally satisfied. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

(C) With respect to a group health plan that offers multiple benefit packages, the plan or issuer is required to provide a new SBC automatically to participants and beneficiaries upon renewal or re-enrollment only with respect to the benefit package in which a participant or beneficiary is enrolled (or will be automatically re-enrolled under the plan); SBCs are not required to be provided automatically upon renewal or re-enrollment with respect to benefit packages in which the participant or beneficiary is not enrolled (or will not automatically be enrolled). However, if a participant or beneficiary requests an SBC with respect to another benefit package (or more than one other benefit package) for which the participant or beneficiary is eligible, the SBC (or SBCs, in the case of a request for SBCs relating to more than one benefit package) must be provided upon request as soon as practicable, but in no event later than seven business days following receipt of the request.

(2) Content – (i) In general. Subject to paragraph (a)(2)(iii) of this section, the SBC must include the following:

(A) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage, in accordance with guidance as specified by the Secretary;

(B) A description of the coverage, including cost sharing, for each category of benefits identified by the Secretary in guidance;

(C) The exceptions, reductions, and limitations of the coverage;

(D) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;

(E) The renewability and continuation of coverage provisions;

(F) Coverage examples, in accordance with the rules of paragraph (a)(2)(ii) of this section;

(G) With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;

(H) A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

(I) Contact information for questions;

(J) For issuers, an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained;

(K) For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;

(L) For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage; and

(M) An Internet address for obtaining the uniform glossary, as described in paragraph (c) of this section, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

(ii) Coverage examples. The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions) in accordance with this paragraph (a)(2)(ii).

(A) Number of examples. The Secretary may identify up to six coverage examples that may be required in an SBC.

(B) Benefits scenarios. For purposes of this paragraph (a)(2)(ii), 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 as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality. The Secretary will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

(C) Illustration of benefit provided. For purposes of this paragraph (a)(2)(ii), to illustrate benefits provided under the plan or coverage for a particular benefits scenario, a plan or issuer simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the plan, policy, or benefit package. The illustration of benefits provided will take into account any cost sharing, excluded benefits, and other limitations on coverage, as specified by the Secretary in guidance.

(iii) Coverage provided outside the United States. In lieu 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. In any case, the plan or issuer must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the plan or coverage within the United States.

(3) Appearance. (i) A group health plan and a health insurance issuer must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than 12-point font.

(ii) A group health plan that utilizes two or more benefit packages (such as major medical coverage and a health flexible spending arrangement) may synthesize the information into a single SBC, or provide multiple SBCs.

(4) Form – (i) An SBC provided by an issuer offering group health insurance coverage to a plan (or its sponsor), may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the following three conditions are satisfied –

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

(ii) An SBC provided by a group health plan or health insurance issuer to a participant or beneficiary may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the requirements of this paragraph (a)(4)(ii) are met.

(A) With respect to participants and beneficiaries covered under the plan, the SBC may be provided electronically as described in this paragraph (a)(4)(ii)(A). However, in all cases, the plan must provide the SBC in paper form if paper form is requested.

(1) In accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b-1;

(2) In connection with online enrollment or online renewal of coverage under the plan; or

(3) In response to an online request made by a participant or beneficiary for the SBC.

(B) With respect to participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if:

(1) The format is readily accessible;

(2) The SBC is provided in paper form free of charge upon request; and

(3) In a case in which the electronic form is an Internet posting, the plan or issuer timely notifies the individual in paper form (such as a postcard) or email 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.

(5) Language. A group health plan or health insurance issuer must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this paragraph (a)(5), a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 29 CFR 2590.715-2719(e) are met as applied to the SBC.

(b) Notice of modification. If a group health plan, or health insurance issuer offering group health insurance coverage, makes any material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective. The notice of modification must be provided in a form that is consistent with the rules of paragraph (a)(4) of this section.

(c) Uniform glossary – (1) In general. A group health plan, and a health insurance issuer offering group health insurance coverage, must make available to participants and beneficiaries the uniform glossary described in paragraph (c)(2) of this section in accordance with the appearance and form and manner requirements of paragraphs (c)(3) and (c)(4) of this section.

(2) Health-coverage-related terms and medical terms. The uniform glossary must provide uniform definitions, specified by the Secretary in guidance, of the following health-coverage-related terms and medical terms:

(i) Allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network co-insurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and

(ii) Such other terms as the Secretary determines are important to define so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits), as specified in guidance.

(3) Appearance. A group health plan, and a health insurance issuer, must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee.

(4) Form and manner. A plan or issuer must make the uniform glossary described in this paragraph (c) available upon request, in either paper or electronic form (as requested), within seven business days after receipt of the request.

(d) Preemption. State laws that require a health insurance issuer to provide an SBC that supplies less information than required under paragraph (a) of this section are preempted.

(e) Failure to provide. A group health plan that willfully fails to provide information required under this section to a participant or beneficiary is subject to a fine of not more than \$1,000 for each such failure. A failure with respect to each participant or beneficiary constitutes a separate offense for purposes of this paragraph (e). The IRS will enforce this section using a process and procedure consistent with section 4980D of the Code.

(f) Applicability. The requirements of this section do not apply to a group health plan benefit package that provides Medicare Advantage benefits pursuant to or 42 U.S.C. Chapter 7, Subchapter XVIII, Part C.

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

Accordingly, 29 CFR Part 2590 is proposed to be amended as follows:

PART 2590 —RULES AND REGULATIONS FOR GROUP HEALTH PLANS

1. The authority citation for Part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161-1168, 1169, 1181-1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L.104-191, 110 Stat. 1936; sec. 401(b), Pub. L. 105-200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110-343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111-148, 124 Stat. 119, as amended by Pub. L. 111-152, 124 Stat. 1029; Secretary of Labor’s Order 1-2011, 77 FR 1088 (January 9, 2012).

2. Section 2590.715-2715 is revised to read as follows:

§ 2590.715-2715 Summary of benefits and coverage and uniform glossary.

(a) Summary of benefits and coverage– (1) In general. A group health plan (and its administrator as defined in section 3(16)(A) of ERISA)), and a health insurance issuer offering group health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

(i) SBC provided by a group health insurance issuer to a group health plan – (A) Upon application. A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application for health coverage, as soon as practicable following receipt of the application, but in no event later

than seven business days following receipt of the application. If an SBC was provided before application pursuant to paragraph (a)(1)(i)(D) of this section (relating to SBCs upon request), this paragraph (a)(1)(i)(A) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information required, a new SBC that includes the correct information must be provided upon application pursuant to this paragraph (a)(1)(i)(A).

(B) By first day of coverage (if there are 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 issuer must update and provide a current SBC to the plan (or its sponsor) no later than the first day of coverage.

(C) Upon renewal, reissuance, or re-enrollment. If the issuer renews or reissues a policy, certificate, or contract of insurance for a succeeding policy year, or automatically re-enrolls the policyholder or its participants and beneficiaries in coverage, the issuer must provide a new SBC as follows:

(1) If written application is required (in either paper or electronic form) for renewal or reissuance, the SBC must be provided no later than the date the written application materials are distributed.

(2) If renewal, reissuance, or re-enrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, 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.

(D) Upon request. If a group health plan (or its sponsor) requests an SBC or summary information about a health insurance product from a health insurance issuer offering group health insurance coverage, an SBC must be provided as soon as practicable, but in no event later than seven business days following receipt of the request.

(ii) SBC provided by a group health insurance issuer and a group health plan to participants and beneficiaries – (A) In general. A group health plan (including its administrator, as defined under section 3(16) of ERISA), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary (as defined under sections 3(7) and 3(8) of ERISA), and consistent with the rules of paragraph (a)(1)(iii) of this section, with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.

(B) Upon application. 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, the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage for the participant or any beneficiaries. If an SBC was provided before application pursuant to paragraph (a)(1)(ii)(F) of this section (relating to SBCs upon request), this paragraph (a)(1)(ii)(B) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been is a change in the

information content, a new SBC that includes the correct information must be provided upon application pursuant to this paragraph (a)(1)(ii)(B).

(C) By first day of coverage (if there are changes). If there is any change to 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 to a participant or beneficiary no later than the first day of coverage.

(D) Special enrollees. The plan or issuer must provide the SBC to special enrollees (as described in § 2590.701-6) no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is 90 days from enrollment.

(E) Upon renewal, reissuance, or re-enrollment. If the plan or issuer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), or automatically re-enrolls participants and beneficiaries in coverage, the plan or issuer must provide a new SBC, as follows:

(1) If written application is required for renewal, reissuance, or re-enrollment (in either paper or electronic form), the SBC must be provided no later than the date on which the written application materials are distributed.

(2) If renewal, reissuance, or re-enrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, 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.

(F) Upon request. A plan or issuer must provide the SBC to participants or beneficiaries 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.

(iii) Special rules to prevent unnecessary duplication with respect to group health coverage – (A) An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with the other rules of this section. Therefore, for example, in the case of a group health plan funded through an insurance policy, the plan satisfies the requirement to provide an SBC with respect to an individual if the issuer provides a timely and complete SBC to the individual. An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual that contracts with another party to provide such SBC is considered to satisfy the requirement to provide such SBC if:

(1) The entity monitors performance under the contract;

(2) If the entity has knowledge that the SBC is not being provided in a manner that satisfies the requirements of this section and the entity has all information necessary to correct the noncompliance, the entity corrects the noncompliance as soon as practicable; and

(3) If the entity has knowledge the SBC is not being provided in a manner that satisfies the requirements of this section and the entity does not have all information

necessary to correct the noncompliance, the entity communicates with participants and beneficiaries who are affected by the noncompliance regarding the noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

(B) If a single SBC is provided to a participant and any beneficiaries at the participant's last known address, then the requirement to provide the SBC to the participant and any beneficiaries is generally satisfied. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

(C) With respect to a group health plan that offers multiple benefit packages, the plan or issuer is required to provide a new SBC automatically to participants and beneficiaries upon renewal or re-enrollment only with respect to the benefit package in which a participant or beneficiary is enrolled (or will be automatically re-enrolled under the plan); SBCs are not required to be provided automatically upon renewal or re-enrollment with respect to benefit packages in which the participant or beneficiary is not enrolled (or will not automatically be enrolled). However, if a participant or beneficiary requests an SBC with respect to another benefit package (or more than one other benefit package) for which the participant or beneficiary is eligible, the SBC (or SBCs, in the case of a request for SBCs relating to more than one benefit package) must be provided upon request as soon as practicable, but in no event later than seven business days following receipt of the request.

(2) Content – (i) In general. Subject to paragraph (a)(2)(iii) of this section, the SBC must include the following:

(A) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage, in accordance with guidance as specified by the Secretary;

(B) A description of the coverage, including cost sharing, for each category of benefits identified by the Secretary in guidance;

(C) The exceptions, reductions, and limitations of the coverage;

(D) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;

(E) The renewability and continuation of coverage provisions;

(F) Coverage examples, in accordance with the rules of paragraph (a)(2)(ii) of this section;

(G) With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;

(H) A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

(I) Contact information for questions;

(J) For issuers, an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained;

(K) For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;

(L) For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage; and

(M) An Internet address for obtaining the uniform glossary, as described in paragraph (c) of this section, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

(ii) Coverage examples. The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions) in accordance with this paragraph (a)(2)(ii).

(A) Number of examples. The Secretary may identify up to six coverage examples that may be required in an SBC.

(B) Benefits scenarios. For purposes of this paragraph (a)(2)(ii), 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 as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality. The Secretary will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

(C) Illustration of benefit provided. For purposes of this paragraph (a)(2)(ii), to illustrate benefits provided under the plan or coverage for a particular benefits scenario, a plan or issuer simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the

plan, policy, or benefit package. The illustration of benefits provided will take into account any cost sharing, excluded benefits, and other limitations on coverage, as specified by the Secretary in guidance.

(iii) Coverage provided outside the United States. In lieu 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. In any case, the plan or issuer must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the plan or coverage within the United States.

(3) Appearance. (i) A group health plan and a health insurance issuer must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than 12-point font.

(ii) A group health plan that utilizes two or more benefit packages (such as major medical coverage and a health flexible spending arrangement) may synthesize the information into a single SBC, or provide multiple SBCs.

(4) Form – (i) An SBC provided by an issuer offering group health insurance coverage to a plan (or its sponsor), may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the following three conditions are satisfied –

(A) The format is readily accessible by the plan (or its sponsor);

(B) The SBC is provided in paper form free of charge upon request; and

(C) If the electronic form is an Internet posting, the issuer timely advises the plan (or its sponsor) in paper form or email that the documents are available on the Internet and provides the Internet address.

(ii) An SBC provided by a group health plan or health insurance issuer to a participant or beneficiary may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the requirements of this paragraph (a)(4)(ii) are met.

(A) With respect to participants and beneficiaries covered under the plan, the SBC may be provided electronically as described in this paragraph (a)(4)(ii)(A). However, in all cases, the plan must provide the SBC in paper form if paper form is requested.

(1) In accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b-1;

(2) In connection with online enrollment or online renewal of coverage under the plan; or

(3) In response to an online request made by a participant or beneficiary for the SBC.

(B) With respect to participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if:

(1) The format is readily accessible;

(2) The SBC is provided in paper form free of charge upon request; and

(3) In a case in which the electronic form is an Internet posting, the plan or issuer timely notifies the individual in paper form (such as a postcard) or email 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.

(5) Language. A group health plan or health insurance issuer must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this paragraph (a)(5), a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of § 2590.715-2719(e) are met as applied to the SBC.

(b) Notice of modification. If a group health plan, or health insurance issuer offering group health insurance coverage, makes any material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective. The notice of modification must be provided in a form that is consistent with the rules of paragraph (a)(4) of this section.

(c) Uniform glossary – (1) In general. A group health plan, and a health insurance issuer offering group health insurance coverage, must make available to participants and beneficiaries the uniform glossary described in paragraph (c)(2) of this section in accordance with the appearance and form and manner requirements of paragraphs (c)(3) and (c)(4) of this section.

(2) Health-coverage-related terms and medical terms. The uniform glossary must provide uniform definitions, specified by the Secretary in guidance, of the following health-coverage-related terms and medical terms:

(i) Allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network co-insurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and

(ii) Such other terms as the Secretary determines are important to define so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits), as specified in guidance.

(3) Appearance. A group health plan, and a health insurance issuer, must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee.

(4) Form and manner. A plan or issuer must make the uniform glossary described in this paragraph (c) available upon request, in either paper or electronic form (as requested), within seven business days after receipt of the request.

(d) Preemption. See § 2590.731. In addition, State laws that require a health insurance issuer to provide an SBC that supplies less information than required under paragraph (a) of this section are preempted.

(e) Failure to provide. A group health plan that willfully fails to provide information required under this section to a participant or beneficiary is subject to a fine of not more than \$1,000 for each such failure. A failure with respect to each participant or beneficiary constitutes a separate offense for purposes of this paragraph (e). The Department will enforce this section using a process and procedure consistent with 29 CFR 2560.502c-2 of this chapter and 29 CFR Part 2570, Subpart C.

(f) Applicability. The requirements of this section do not apply to a group health plan benefit package that provides Medicare Advantage benefits pursuant to or 42 U.S.C. Chapter 7, Subchapter XVIII, Part C.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Subtitle A

For the reasons stated in the preamble, the Department of Health and Human Services proposes to amend 45 CFR part 147 as follows:

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

1. The authority citation for part 147 continues to read as follows:

Authority: Sections 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

2. Revise § 147.200 to read as follows:

§ 147.200 Summary of benefits and coverage and uniform glossary.

(a) Summary of benefits and coverage– (1) In general. A group health plan (and its administrator as defined in section 3(16)(A) of ERISA)), and a health insurance issuer offering group or individual health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

(i) SBC provided by a group health insurance issuer to a group health plan – (A) Upon application. A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application for health coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. If an SBC was provided before application pursuant to paragraph (a)(1)(i)(D) of this section (relating to SBCs

upon request), this paragraph (a)(1)(i)(A) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information required, a new SBC that includes the correct information must be provided upon application pursuant to this paragraph (a)(1)(i)(A).

(B) By first day of coverage (if there are 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 issuer must update and provide a current SBC to the plan (or its sponsor) no later than the first day of coverage.

(C) Upon renewal, reissuance, or re-enrollment. If the issuer renews or reissues a policy, certificate, or contract of insurance for a succeeding policy year, or automatically re-enrolls the policyholder or its participants and beneficiaries in coverage, the issuer must provide a new SBC as follows:

(1) If written application is required (in either paper or electronic form) for renewal or reissuance, the SBC must be provided no later than the date the written application materials are distributed.

(2) If renewal, reissuance, or re-enrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, 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.

(D) Upon request. If a group health plan (or its sponsor) requests an SBC or summary information about a health insurance product from a health insurance issuer offering group health insurance coverage, an SBC must be provided as soon as practicable, but in no event later than seven business days following receipt of the request.

(ii) SBC provided by a group health insurance issuer and a group health plan to participants and beneficiaries – (A) In general. A group health plan (including its administrator, as defined under section 3(16) of ERISA), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary (as defined under sections 3(7) and 3(8) of ERISA), and consistent with the rules of paragraph (a)(1)(iii) of this section, with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.

(B) Upon application. 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, the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage for the participant or any beneficiaries. If an SBC was provided before application pursuant to paragraph (a)(1)(ii)(F) of this section (relating to SBCs upon request), this paragraph (a)(1)(ii)(B) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been is a change in the information content, a new SBC that includes the correct information must be provided upon application pursuant to this paragraph (a)(1)(ii)(B).

(C) By first day of coverage (if there are changes). If there is any change to 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 to a participant or beneficiary no later than the first day of coverage.

(D) Special enrollees. The plan or issuer must provide the SBC to special enrollees (as described in §146.117 of this subchapter) no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is 90 days from enrollment.

(E) Upon renewal, reissuance, or re-enrollment. If the plan or issuer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), or automatically re-enrolls participants and beneficiaries in coverage, the plan or issuer must provide a new SBC, as follows:

(1) If written application is required for renewal, reissuance, or re-enrollment (in either paper or electronic form), the SBC must be provided no later than the date on which the written application materials are distributed.

(2) If renewal, reissuance, or re-enrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, 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.

(F) Upon request. A plan or issuer must provide the SBC to participants or beneficiaries 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.

(iii) Special rules to prevent unnecessary duplication with respect to group health coverage – (A) An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with the other rules of this section. Therefore, for example, in the case of a group health plan funded through an insurance policy, the plan satisfies the requirement to provide an SBC with respect to an individual if the issuer provides a timely and complete SBC to the individual. An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual that contracts with another party to provide such SBC is considered to satisfy the requirement to provide such SBC if:

(1) The entity monitors performance under the contract;

(2) If the entity has knowledge that the SBC is not being provided in a manner that satisfies the requirements of this section and the entity has all information necessary to correct the noncompliance, the entity corrects the noncompliance as soon as practicable; and

(3) If the entity has knowledge the SBC is not being provided in a manner that satisfies the requirements of this section and the entity does not have all information necessary to correct the noncompliance, the entity communicates with participants and beneficiaries who are affected by the noncompliance regarding the regarding the

noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

(B) If a single SBC is provided to a participant and any beneficiaries at the participant's last known address, then the requirement to provide the SBC to the participant and any beneficiaries is generally satisfied. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

(C) With respect to a group health plan that offers multiple benefit packages, the plan or issuer is required to provide a new SBC automatically to participants and beneficiaries upon renewal or re-enrollment only with respect to the benefit package in which a participant or beneficiary is enrolled (or will be automatically re-enrolled under the plan); SBCs are not required to be provided automatically upon renewal or re-enrollment with respect to benefit packages in which the participant or beneficiary is not enrolled (or will not automatically be enrolled). However, if a participant or beneficiary requests an SBC with respect to another benefit package (or more than one other benefit package) for which the participant or beneficiary is eligible, the SBC (or SBCs, in the case of a request for SBCs relating to more than one benefit package) must be provided upon request as soon as practicable, but in no event later than seven business days following receipt of the request.

(iv) SBC provided by a health insurance issuer offering individual health insurance coverage -- (A) Upon application. A health insurance issuer offering individual health insurance coverage must provide an SBC to an individual covered under the policy (including every dependent) upon receiving an application for any health

insurance policy, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. If an SBC was provided before application pursuant to paragraph (a)(1)(iv)(D) of this section (relating to SBCs upon request), this paragraph (a)(1)(iv)(A) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been is a change in the information content, a new SBC that includes the correct information must be provided upon application pursuant to this paragraph (a)(1)(iv)(A).

(B) By first day of coverage (if there are 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 issuer must update and provide a current SBC to the individual no later than the first day of coverage.

(C) Upon renewal, reissuance, or re-enrollment. If the issuer renews or reissues a policy, certificate, or contract of insurance for a succeeding policy year, or automatically re-enrolls an individual (or dependent) covered under a policy, certificate, or contract of insurance into a policy, certificate, or contract of insurance under a different plan or product, the issuer must provide an SBC for the coverage in which the individual (including every dependent) will be enrolled, as follows:

(1) If written application is required (in either paper or electronic form) for renewal, reissuance, or re-enrollment, the SBC must be provided no later than the date on which the written application materials are distributed.

(2) If renewal, reissuance, or re-enrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of the new policy year; however, if the policy, certificate, or contract of insurance has not been issued or renewed before

such 30 day period, 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.

(D) Upon request. A health insurance issuer offering individual health insurance coverage must provide an SBC to any individual or dependent upon request for an SBC or summary information about a health insurance product as soon as practicable, but in no event later than seven business days following receipt of the request.

(v) Special rule to prevent unnecessary duplication with respect to individual health insurance coverage.-----(A) In general. If a single SBC is provided to an individual and any dependents at the individual's last known address, then the requirement to provide the SBC to the individual and any dependents is generally satisfied. However, if a dependent's last known address is different than the individual's last known address, a separate SBC is required to be provided to the dependent at the dependents' last known address.

(B) Student health insurance coverage. With respect to student health insurance coverage as defined at §147.145(a) , the requirement to provide an SBC to an individual will be considered satisfied for an entity if another party provides a timely and complete SBC to the individual.

(2) Content – (i) In general. Subject to paragraph (a)(2)(iii) of this section, the SBC must include the following:

(A) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage, in accordance with guidance as specified by the Secretary;

(B) A description of the coverage, including cost sharing, for each category of benefits identified by the Secretary in guidance;

(C) The exceptions, reductions, and limitations of the coverage;

(D) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;

(E) The renewability and continuation of coverage provisions;

(F) Coverage examples, in accordance with the rules of paragraph (a)(2)(ii) of this section;

(G) With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;

(H) A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

(I) Contact information for questions;

(J) For issuers, an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained;

(K) For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;

(L) For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage;

(M) An Internet address for obtaining the uniform glossary, as described in paragraph (c) of this section, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available; and

(N) For qualified health plans sold through an individual market Exchange that exclude or provide for coverage of the services described in §156.280(d)(1) of this subchapter, a notice of exclusion or such coverage.

(ii) Coverage examples. The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions) in accordance with this paragraph (a)(2)(ii).

(A) Number of examples. The Secretary may identify up to six coverage examples that may be required in an SBC.

(B) Benefits scenarios. For purposes of this paragraph (a)(2)(ii), 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 as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality. The Secretary will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

(C) Illustration of benefit provided. For purposes of this paragraph (a)(2)(ii), to illustrate benefits provided under the plan or coverage for a particular benefits scenario, a plan or issuer simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the

plan, policy, or benefit package. The illustration of benefits provided will take into account any cost sharing, excluded benefits, and other limitations on coverage, as specified by the Secretary in guidance.

(iii) Coverage provided outside the United States. In lieu 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. In any case, the plan or issuer must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the plan or coverage within the United States.

(3) Appearance. (i) A group health plan and a health insurance issuer must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee (or, in the case of individual market coverage, the average individual covered under a health insurance policy), not exceed four double-sided pages in length, and not include print smaller than 12-point font. A health insurance issuer offering individual health insurance coverage must provide the SBC as a stand-alone document.

(ii) A group health plan that utilizes two or more benefit packages (such as major medical coverage and a health flexible spending arrangement) may synthesize the information into a single SBC, or provide multiple SBCs.

(4) Form – (i) An SBC provided by an issuer offering group health insurance coverage to a plan (or its sponsor), may be provided in paper form. Alternatively, the

SBC may be provided electronically (such as by email or an Internet posting) if the following three conditions are satisfied –

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

(ii) An SBC provided by a group health plan or health insurance issuer to a participant or beneficiary may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the requirements of this paragraph (a)(4)(ii) are met.

(A) With respect to participants and beneficiaries covered under the plan or coverage, the SBC may be provided electronically as described in this paragraph (a)(4)(ii)(A). However, in all cases, the plan or issuer must provide the SBC in paper form if paper form is requested.

(1) In accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b-1;

(2) In connection with online enrollment or online renewal of coverage under the plan; or

(3) In response to an online request made by a participant or beneficiary for the SBC.

(B) With respect to participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if:

(1) The format is readily accessible;

(2) The SBC is provided in paper form free of charge upon request; and

(3) In a case in which the electronic form is an Internet posting, the plan or issuer timely notifies the individual in paper form (such as a postcard) or email 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.

(iii) An issuer offering individual health insurance coverage must provide an SBC in a manner that can reasonably be expected to provide actual notice in paper or electronic form.

(A) An issuer satisfies the requirements of this paragraph (a)(4)(iii) if the issuer:

(1) Hand-delivers a printed copy of the SBC to the individual or dependent;

(2) Mails a printed copy of the SBC to the mailing address provided to the issuer by the individual or dependent;

(3) Provides the SBC by e-mail after obtaining the individual's or dependent's agreement to receive the SBC or other electronic disclosures by e-mail;

(4) Posts the SBC on the Internet and advises the individual or dependent in paper or electronic form, in a manner compliant with paragraphs (a)(4)(iii)(A)(1) through (3), that the SBC is available on the Internet and includes the applicable Internet address; or

(5) Provides the SBC by any other method that can reasonably be expected to provide actual notice.

(B) An SBC may not be provided electronically unless:

(1) The format is readily accessible;

(2) The SBC is placed in a location that is prominent and readily accessible;

(3) The SBC is provided in an electronic form which can be electronically retained and printed;

(4) The SBC is consistent with the appearance, content, and language requirements of this section;

(5) The issuer notifies the individual or dependent that the SBC is available in paper form without charge upon request and provides it upon request.

(C) Deemed compliance. A health insurance issuer offering individual health insurance coverage that provides the content required under paragraph (a)(2) of this section, as specified in guidance published by the Secretary, to the federal health reform Web portal described in §159.120 of this subchapter will be deemed to satisfy the requirements of paragraph (a)(1)(iv)(D) of this section with respect to a request for summary information about a health insurance product made prior to an application for coverage. However, nothing in this paragraph should be construed as otherwise limiting such issuer's obligations under this section.

(iv) An SBC provided by a self-insured non-Federal governmental plan may be provided in paper form. Alternatively, the SBC may be provided electronically if the plan conforms to either the substance of the provisions in paragraph (a)(4)(ii) or (a)(4)(iii) of this section.

(5) Language. A group health plan or health insurance issuer must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this paragraph (a)(5), a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of §147.136(e) are met as applied to the SBC.

(b) Notice of modification. If a group health plan, or health insurance issuer offering group or individual health insurance coverage, makes any material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees (or, in the case of individual market coverage, an individual covered under a health insurance policy) not later than 60 days prior to the date on which the modification will become effective. The notice of modification must be provided in a form that is consistent with the rules of paragraph (a)(4) of this section.

(c) Uniform glossary – (1) In general. A group health plan, and a health insurance issuer offering group health insurance coverage, must make available to participants and beneficiaries, and a health insurance issuer offering individual health insurance coverage must make available to applicants, policyholders, and covered dependents, the uniform glossary described in paragraph (c)(2) of this section in accordance with the appearance and form and manner requirements of paragraphs (c)(3) and (c)(4) of this section.

(2) Health-coverage-related terms and medical terms. The uniform glossary must provide uniform definitions, specified by the Secretary in guidance, of the following health-coverage-related terms and medical terms:

(i) Allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care,

hospice services, hospitalization, hospital outpatient care, in-network co-insurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and

(ii) Such other terms as the Secretary determines are important to define so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits), as specified in guidance.

(3) Appearance. A group health plan, and a health insurance issuer, must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee (or, in the case of individual market coverage, an average individual covered under a health insurance policy).

(4) Form and manner. A plan or issuer must make the uniform glossary described in this paragraph (c) available upon request, in either paper or electronic form (as requested), within seven business days after receipt of the request.

(d) Preemption. For purposes of this section, the provisions of section 2724 of the PHS Act continue to apply with respect to preemption of State law. In addition, State laws that require a health insurance issuer to provide an SBC that supplies less information than required under paragraph (a) of this section are preempted.

(e) Failure to provide. A health insurance issuer or a non-federal governmental health plan that willfully fails to provide information to a covered individual required under this section is subject to a fine of not more than \$1,000 for each such failure. A failure with respect to each covered individual constitutes a separate offense for purposes of this paragraph (e). HHS will enforce these provisions in a manner consistent with §§150.101 through 150.465 of this subchapter.

(f) Applicability. The requirements of this section do not apply to a group health plan benefit package that provides Medicare Advantage benefits pursuant to or 42 U.S.C. Chapter 7, Subchapter XVIII, Part C.

[FR Doc. 2014-30243 Filed 12/22/2014 at 4:15 pm; Publication Date:
12/30/2014]