Summary of Benefits and Coverage
Frequently Asked Questions

The following FAQs have been prepared to provide information to help you to understand and comply with the final regulations that were issued by the U.S. Departments of Treasury, Labor and Health and Human Services (the Departments) relating to the Summary of Benefits and Coverage requirements under the Affordable Care Act (ACA). The ACA requires that an accurate Summary of Benefits and Coverage (SBC) document must be provided to individuals who are considering enrollment into a health plan, or are already enrolled in a plan (i.e., applicants, enrollees and beneficiaries, including dependents). The final regulations address who is required provide the SBC, to whom it should be sent, when it must be sent, and what information must be contained within the SBC upon distribution. In addition, the final regulations outline standards regarding the use of terminology commonly used across the industry to describe benefits. The SBC regulations also require a 60-day advance notice to plan participants of any material modification to the terms of their plan or coverage after the plan's effective date. SBCs are required to be distributed by the group health plan beginning with the **first open enrollment period** (including re-enrollees) beginning on or after September 23, 2012.

To whom do these final regulations apply?

All group health plans and insurers that must comply with ACA, including insured and self-funded group health plans (both ERISA and non-ERISA).

Do these final regulations apply to grandfathered health plans?

Yes. The SBC regulations apply to both grandfathered and non-grandfathered health plans.

Are there any plans or benefits for which the SBC regulations do not apply?

Yes, very small plans (groups with less than 2 participants that are current employees), stand-alone retiree-only health plans and excepted benefits. Excepted benefits generally include dental-only and/or vision-only plans, most health flexible spending accounts (FSA), Medigap policies and accidental death and dismemberment coverage.

How do I determine if my plan is an excepted benefit?

Excepted benefits can generally be explained as benefits that are separate from your medical coverage and require an additional premium to be paid to obtain such coverage. For example, a Health FSA is generally considered excepted if the following conditions are satisfied:

1. Currently, the maximum benefit under the Health FSA cannot exceed two times the employee's salary reduction election under the Health FSA for the year (or, if greater, the amount of the employee's salary reduction election for the Health FSA for the year, plus $500); and

2. The employee has other coverage available under a group health plan sponsored by the same employer for the year and such "other" coverage is not limited to benefits that are excepted benefits (i.e., stand-alone dental or vision).

You should know whether or not the benefits you are offering are excepted benefits. If you need assistance in making this determination, please reach out to your assigned Client Services Manager, and he or she will be happy to discuss this topic further with you.

Is a Health Savings Account (HSA) considered a group health plan?

No, HSAs are not group health plans. The preamble of the final SBC regulations states that HSAs are not subject to this requirement, but a group that wishes to include information about their HSA plan in the SBC of their high-deductible health plan is permitted to do so.

Do I have to provide a separate SBC for my FSA plan?

Yes, unless your FSA plan is an excepted benefit plan. The final regulations allow FSA plans that are integrated with a medical plan to reflect the terms of the FSA plan within the medical SBC. If you offer a stand-alone FSA plan that is not considered an excepted benefit, then you must comply with these final regulations and provide a separate SBC for this benefit.

Limited purpose FSAs do not have to comply with the SBC requirement. A limited purpose FSA is an arrangement that pays benefits only for certain permitted expenses such as dental and vision.

I offer a Health Reimbursement Arrangement (HRA). Do I have to comply with these final regulations?

Most HRA plans do not meet the definition of an excepted benefit and therefore, an SBC must be generated and provided; however, as with FSAs, if an HRA plan is integrated with a medical plan, the terms of the HRA plan may be reflected in the SBC of the integrated medical plan. Free standing HRA plans that are not integrated with a medical plan would require a separate SBC.

If your HRA is considered a retiree-only HRA plan (meaning the plan only reimburses expenses after employment terminates), then this type of HRA would not have to comply with the SBC requirements.

Are expatriate plans required to provide SBCs pursuant to the standards?

Expatriate plans are not specifically exempt from the SBC requirements; however, the final rule does include a special rule for coverage provided outside of the United States. The final rule states that in lieu of summarizing the coverage provided outside of the United States, a plan or issuer may provide an Internet address (or similar contact information) for obtaining information about coverage or benefits provided outside of the United States. To the extent that coverage or benefits are available within the United States, the plan or issuer is still required to provide an SBC in accordance with the standards in the final rule.

In the FAQ issued jointly by the Departments of Health and Human Services, Labor, and Treasury on May 11, 2012, the Departments provide an enforcement safe harbor for group health plans and issuers for failing to provide an SBC with respect to expatriate coverage during the first year of applicability.

Is this document in addition to the Summary Plan Description (SPD) we are required to offer under ERISA?

Yes. This is a separate document from the SPD. The final regulations allow plans to include the SBC with their SPD as long as the SBC is intact (i.e., in the complete, required format stipulated by the final regulations) and prominently displayed at the beginning of the document.

Is the Health Plan permitted to charge plan participants for this document?

No. The document must be provided to plan participants free of charge.

When must we comply with these final regulations?

SBCs are required to be distributed by the group health plan beginning with the **first open enrollment period** (including re-enrollees) beginning on or after September 23, 2012.

Outlined below are some examples of how the SBC requirements apply in different open enrollment and renewal effective date scenarios:

Plan year dates for new enrollment or renewals	Open enrollment start dates	Is an SBC required for open enrollment?	SBCs required for newly eligible and special enrollees
10/1/2012	8/27/2012	No	10/1/2012 or later
11/1/2012	9/17/2012	No	11/1/2012
1/1/2013	10/15/2012	Yes	1/1/2013

Must an SBC be provided if we do not have an open enrollment period?

Yes. An SBC is at least required to be distributed at the start of each plan year beginning with the first plan year on or after September 23, 2012.

Are we able to include the notice with other open enrollment material?

Yes. Notice may be included in any open enrollment materials as long as it is prominently displayed at the beginning of the materials.

May the notice be provided to the employee on behalf of the dependent?

Yes. The notice may be provided to the employee on behalf of a dependent **if they reside at the same address**.

What are the key requirements which must be complied with when drafting the SBC?

The final SBC regulations are designed to guide the construction of the SBC in the following areas: appearance, language, form and content.

1. **Appearance** – An SBC must be presented in a "uniform format," which may not exceed four pages (double sided) in length, and may not include print smaller than 12-point font.

2. **Language –** An SBC must be presented in a culturally and linguistically appropriate manner and must utilize terminology easily understood by the average plan enrollee. The final rule follows the same standards for language assistance that were adopted in the internal claims and appeals and external review regulation. Under this standard, plans and issuers will be required to disclose the availability of language assistance in non-English languages, and support any language assistance requests in such languages, based on county level census data. Currently the law requires support for four non-English languages including: Spanish, Mandarin, Tagalog and Navajo.

3. **Form** – An SBC can always be provided in paper form, and can be provided in electronic form if additional requirements are met. The requirements vary for electronic delivery depending on the market involved, and, in the group market, depending on whether the participant is currently enrolled in coverage or not.

4. **Content** – At a minimum, ACA requires an SBC to include:

a. uniform definitions of standard insurance and medical terms (as part of a “uniform glossary”);
b. a description of the coverage, including cost-sharing; exceptions, reductions, and limitations on coverage;
c. the exceptions, reductions, and limitations of the coverage;
d. the cost-sharing provisions;
e. the renewability and continuation of coverage provisions;
f. coverage examples;
g. a statement of whether the plan or coverage provides minimum essential coverage and a minimum value statement, with respect to coverage beginning on or after January 1, 2014;
h. a statement that the outline is a summary and that the coverage document itself should be consulted to determine the controlling contractual provisions; and
i. contract information for questions and obtaining a copy of the plan document or policy.

The final rule also includes as applicable, contact information for obtaining a list of network providers, information on prescription drug coverage, as well as an Internet address and a contact phone number for obtaining the uniform glossary, and a disclosure that paper copies are available

Are there any special rules for plans that do not fit the SBC template?

Yes. The Guidance for Compliance and the SBC instructions provide a special rule. Under this rule, if the plan’s terms that are required to be included in the SBC cannot be reasonably described consistent with the template and the instructions, the plan or issuer is required to accurately describe the plan’s terms while using its best efforts in a manner that is still consistent with the instructions and template.

Are plans and carriers required to distribute the uniform glossary?

Yes, under the final rule, a plan or issuer would be required to make the uniform glossary available upon request. The uniform glossary is a standard document that must be provided in the form that was issued by the Departments.

Am I permitted to provide the SBC electronically as opposed to printing and mailing the SBC?

The final regulations allow electronic distribution of the SBC as long as certain requirements are met. For participants who are already enrolled in the group health plan, the plan must comply with the Department of Labor’s regulations at 29 CFR 2520.104b–1, unless the SBC is provided as part of an employee’s online enrollment or renewal process.

For participants who are eligible but not yet covered under the health plan, an SBC may be provided electronically if the format is readily accessible, and a paper copy is available to the individual free of charge and upon request. Plans who post the SBC electronically on an Internet site must inform individuals via a postcard or some other paper form or e-mail that the document is available. They must also provide the web address and their right to obtain a paper copy upon request. A sample postcard was issued as part of Department of Labor FAQ VIII and can be found by accessing the link: http://www.dol.gov/ebsa/faqs/faq-aca8.html

Are we only required to issue the SBC at Open Enrollment?

No. There are "triggers" that would require a group health plan to issue the SBC outside of the open enrollment window. Those triggering events and the timing associated with distribution of the SBC are summarized below:

Trigger	Timing	Comments
Enrollment Periods (including Open Enrollment and Enrollment for Newly Eligbibles)	No later than when the plan would provide other written information about the enrollment process	If the plan does not provide enrollment materials, the SBC must be provided by the first day in which the participant is **eligible** to enroll in the plan.
Effective date of plan coverage	By the first day of plan coverage	This action is required only if there are changes to the SBC that were previously provided with enrollment/ application materials.
Upon renewal	**Re-enrollment required on the part of the participant:** Must be provided with other enrollment materials. **Re-enrollment is automatic:** No later than 30 calendar days prior to the first day of the new plan year.** ** There is an exception for fully insured plans, when a decision has not been made whether the plan is renewing. In that case, if the 30 calendar day time period is not achievable, the SBC must be provided within seven (7) business days after issuance of the new policy.	For plans that offer more then one plan option, they are only required to automatically provide the SBC for which the participant is enrolled; however, if an SBC is requested for another benefit option, that SBC must be provided no later than seven (7) business days from the request.
During special enrollments	No later than 90 calendar days from enrollment.	
Upon request	As soon as possible but no later than seven (7) business days following receipt of the request.	
Upon material modification (during plan year, as defined under ERISA)	60 calendar days prior to the effective date of the material modification.	A notice outlining the changes or a new SBC may be issued to satisfy this requirement.

Do the final regulations include a penalty for noncompliance?

Yes; however, according to U.S.Department of Labor SBC FAQ Part VIII, "Consistent with this guidance, during this first year of applicability, the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations." The first year of applicability is September 23, 2012 – September 23, 2012.

Any willful and intentional failure to comply with the SBC requirements may result in a daily penalty of up to $1,000 per willful failure per participant and up to $100 a day per participant in excise taxes. Each enrollee is considered an independent failure.

What if a health plan or issuer modifies the terms of the plan or coverage involved?

If at any time a health plan or issuer makes material modification(s) to the terms of the plan or coverage involved that is/are not reflected in the most recently provided SBC, the plan or issuer must provide notice of the modification to enrollees at least 60 days in advance of the effective date of the change. The requirement for the Notice of Material Modification is not triggered upon renewal. The Notice of Material Modification may be satisfied by providing an updated SBC or a separate notice.

Is the requirement to provide the Notice of Material Modification effective before an SBC is triggered?

No. In an FAQ released by the Departments on December 22, 2010, they confirmed that group health plans and health insurance issuers are not required to comply with the 60-day prior notice requirement until plans or issuers are required to provide the SBCs. This notice of material modification requirement does not apply to any document being currently used by plan participants or any other document other than the SBC required by PHSA Section 2715.

Did the Interim Regs provide model documents that could be used to satisfy this requirement?

Yes. Templates and instructions can be found on the Department of Labor's website by accessing the following link: http://www.dol.gov/ebsa/healthreform/index.html. In addition, the Departments' sample completed SBC is available at: http://www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf

However, the Departments have stated a non-enforcement policy will be in place for the first year as long as best efforts are followed in a manner as reasonable and consistent as possible with the instructions and template format.

The model documents ask for a lot of information that is not applicable in an FSA and/or HRA plan. Are there model document somewhere that would better work for an FSA and/or has plan?

No. The current SBC templates do not take into account the unique arrangement of a health FSA or HRA. PayFlex is actively working with government officials to receive approval for a more appropriate format for non-excepted FSAs and HRAs. As discussed above, if the plan's terms that are required to be included in the SBC cannot be reasonably described consistent with the template and the instructions, the plan or issuer is required to accurately describe the plan's terms while using its best efforts in a manner that is still consistent with the instructions and template.

Is there additional information available that may be helpful to us in figuring out our obligations to comply?

FAQs published by the Department about PPACA Implementation Part VIII and IX are available at http://www.dol.gov/ebsa/healthreform.

Will PayFlex assist me with complying with this requirement?

Yes. PayFlex will provide you with as much information as possible, however; since we do not have all of the details needed to adequately complete the SBC, we are unable to prepare or deliver the SBC on your behalf. You are responsible for completing and distributing the SBC in accordance with the regulations. We recommend that you carefully review the SBC regulations to fully understand the requirements, including the financial risk of non-compliance and the foreign language requirement you must comply with.