ACA: SUMMARY OF BENEFITS AND COVERAGE REQUIREMENT

The Affordable Care Act (ACA) generally requires group health plans and health insurance issuers that offer group health coverage to prepare and distribute to plan participants and beneficiaries a brief standard summary of the plan's benefits and coverage. This summary is called the summary of benefits and coverage (SBC). In order to help employers fulfill their administrative responsibilities in connection with the SBC requirement, this publication provides information regarding the types of plans subject to the requirement, the content, timing and delivery of the SBC (including when material modifications to the SBC occur outside of the policy renewal cycle), and the penalties for noncompliance with the SBC content and delivery requirements. For information about employers that are subject to the broad range of ACA requirements, see the PPI publication **ACA: Applicable Large Employers**.

Under the ACA, plan administrators of group health plans must provide to participants and beneficiaries an SBC that accurately describes the benefits and coverages under the plan.

BACKGROUND

Under the ACA, plan administrators of group health plans (or health insurance issuers in the case of fully insured plans) must provide participants and beneficiaries an SBC that accurately describes the benefits and coverages of each benefit package under the plan. Also, the health insurance issuer (often referred to as the insurer or carrier) must provide an SBC to the group health plan sponsor (generally the employer). The SBC requirement is in addition to the summary plan description (SPD) and summary of material modification (SMM) requirements that pertain to ERISA plans. For further information about ERISA requirements related to group health plans, see the PPI publication **ERISA Compliance Considerations for Health and Welfare Benefit Plans**.

The purpose of the SBC requirement is to provide employees and their eligible dependents (also referred to as beneficiaries) with a basis for understanding the health coverage offered under the plan and a means for comparing various health plans and policies. To achieve this purpose, the SBC is subject to strict content, appearance, format and language requirements. Importantly, the SBC must include a uniform glossary that clearly defines plan and benefit terminology, as well as coverage examples that illustrate benefits provided under the plan or coverage for common benefit scenarios.

In addition, plan sponsors and insurers must provide a notice of material modifications to any terms of the plan or coverage that would affect the content of the SBC. The ACA directs the departments (the DOL, IRS and HHS) to develop standards and definitions to achieve the goal of the SBC and SMM requirements.

In February 2012, the departments published final regulations regarding the SBC requirement as well as a compliance guidance document, instructions for completing SBCs, an SBC template, a sample completed SBC, and a uniform glossary of coverage and medical terms. The SBC requirement became effective for open enrollment periods beginning on and after September 23, 2012. (See links to the final regulations and the additional documents in the Resources section below.) Note that the SBC template and related materials undergo periodic changes as new healthcare reforms take effect.

PLANS SUBJECT TO THE SBC REQUIREMENT

The SBC requirement applies to most group health plans, including self-insured and fully insured plans. Grandfathered plans are also subject to the requirement. Since health reimbursement arrangements (HRAs) generally do not meet the definition of excepted benefits under HIPAA, they are likely subject to the SBC requirement. However, an HRA that is integrated with the major medical coverage can be included in the SBC for the major medical plan rather than issued separately.

Plans that are not subject to the SBC requirement include excepted benefits (as defined in HIPAA), such as stand-alone dental and vision plans and many health flexible spending accounts (FSAs) and retiree-only plans (a plan that covers less than two current employees as participants). Note that Excepted Benefit HRAs (EBHRAs) and Qualified Small Employer HRAs (QSEHRAs) are not subject to the SBC requirement, but Individual Coverage Benefit HRAs (ICHRAs) are subject to the requirement. Similarly, health savings accounts (HSAs) are generally not considered "group health plans" and therefore are not subject to the SBC requirement. Nevertheless, an SBC prepared for a high deductible health plan (HDHP) associated with an HSA must reference the effect of employer contributions to the HSA, and the HSA's effect on the HDHP's deductible, in the appropriate spaces. Likewise, even health FSAs and HSAs, which generally are not subject to the SBC requirement, may need to be referenced in an SBC for a comprehensive medical plan if the employer, at its discretion, chooses to use the SBC to explain how the plan's deductible and any copayment features interact with a health FSA or HSA.

Plans Subject to SBC Requirement	Plans Not Subject to SBC Requirement
Fully or self-insured major medical group health plans of any size	Stand-alone dental and stand-alone vision plans
Fully or self-insured qualifying HDHP major medical plans	HIPAA-excepted health FSAs
Fully or self-insured major medical plans that are integrated with an HRA	Retiree-only plans
ICHRAs	EBHRAs and QSEHRAs
	HSAs
	Dependent care FSAs

SBC CONTENT

According to the ACA's strict requirements, SBCs must generally include the following:

- A uniform definition of standard insurance terms and medical coverage
- A description of the plan's coverage for each category of benefits, including cost-sharing
- The plan's benefit exceptions, reductions and limitations
- Information relating to renewability and continuation of coverage
- A "coverage facts label," which includes hypothetical coverage examples to illustrate the benefits that would be provided for certain common benefit scenarios
- Internet addresses or contact information for obtaining a list of network providers, information about any prescription drug formulary, the uniform glossary, and the plan document, insurance policy, contract or certificate of insurance
- A statement that the SBC is only a summary, and that the plan document, insurance policy, contract or certificate of insurance should be consulted for more information about the coverage provided under the plan

With respect to the coverage facts label, the final regulations initially included two coverage examples: one for maternity care and one for Type 2 diabetes. For plan years beginning on or after January 1, 2017, a third coverage example was added: a simple fracture requiring an emergency room visit. The purpose of the coverage examples is to show how claims for specific benefits would be processed so that a participant can see an estimate of cost-sharing and payment. See under the Resources section below for links to the coverage examples. Separately, the Consolidated Appropriations Act of 2021 (CAA) includes other plan requirements regarding the availability of participant cost-sharing tools. For more information about these requirements, see the PPI publication **Transparency and No Surprises Act Obligations of Group Health Plans**.

SBC APPEARANCE, FORM AND LANGUAGE

In addition to the strict content requirements, SBCs must also meet strict requirements with respect to their appearance, form, manner and language. Specifically, they must be printed in 12-point or larger font and must be limited to four double-sided pages.

They must be presented in a uniform format and use terminology understandable by the average enrollee. Plan administrators and insurers are encouraged (although not required) to use the model SBCs provided by the DOL to satisfy the requirements.

With respect to language, the SBC must be provided in a "culturally and linguistically appropriate" manner, similar to the ACA rules for group health plan claims and appeals communications. Generally, the plan must disclose the availability of language services and provide written translation of an SBC for certain counties that have been identified by the US Census Bureau as having a concentration of at least 10 percent of the population who speak the same non-English language. The county list is meant to be updated annually by HHS (see link in the Resources section below; in the absence of annual updates, employers can rely on the most recently published list). HHS will make available written translations of the SBC template, sample language and uniform glossary in Spanish, Tagalog, Chinese and Navajo.

OTHER SBC REQUIREMENTS

SBC Modifications

If the plan sponsor or insurer makes a material modification to the SBC outside of renewal or reissuance (for example, a midyear plan design change) that requires a change in the SBC, the plan sponsor or insurer must provide notice of the modification to enrolled participants and beneficiaries no later than 60 days prior to the date the modification will take effect. The 60-day advance notice may be provided through a separate notice or through an updated SBC.

This SBC modification requirement is in addition to existing ERISA rules, which generally require plan sponsors to provide an SMM within 60 days after adoption of a material reduction in covered benefits (or within 210 days for other plan modifications). However, the final SBC regulations state that if a plan sponsor provides a complete notice or an updated SBC to inform participants of the modification or change, the ERISA requirement to provide an SMM is also satisfied.

Material modifications include, among other things, amendment provisions that establish new benefits, take away existing benefits, narrow or expand the circumstances under which benefits are paid, and terminate the plan entirely. If the amendment changes the information required to be disclosed in an SPD, an SMM should be distributed. One court found that an amendment to an insured plan to exclude high-dose chemotherapy for breast cancer was a material modification. Another court found that a modification of a plan to create two classifications of retirees for purposes of premium contributions was a material modification.

Not all plan amendments constitute material modifications. For example, some courts have held that an amendment that merely clarifies plan language and does not affect substantive plan provisions is not a material modification. Also, a change in how plan administrative expenses were paid did not constitute a material modification triggering the need for an SMM, because plan language already contained provisions permitting the change.

When a material modification includes a material reduction (as distinct from an improvement) in group health plan covered services or benefits, the determination of whether the change must be reflected in the SPD will depend on whether the change would be considered by the average plan participant to be an important (i.e., significant or material) reduction in covered services or benefits. DOL final regulations provide several examples of what qualifies as a group health plan reduction in covered services or benefits. While not inclusive, these examples can be helpful when determining whether a material reduction has occurred:

- An elimination of benefits payable under the plan
- A reduction of benefits payable under the plan (including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations)
- An increase in premiums, deductibles, coinsurance, copayments or other amounts to be paid by a participant or beneficiary
- A reduction in the service area covered by an HMO
- An imposition of new conditions or requirements (i.e., preauthorization requirements) to obtain services or benefits under the plan

If a plan sponsor makes a material reduction in group health plan covered services or benefits that is not discussed as part of the SBC requirement, participants and beneficiaries must be notified of the change within 60 days after the material reduction in covered benefits or services is adopted. Conversely, if a plan sponsor makes a material reduction in group health plan covered services or benefits that is discussed as part of the SBC requirement, and if the plan sponsor provides a separate SMM notice or an updated SBC at least 60 days before the change is effective, then the ERISA requirement to provide a Notice of Reduction in Benefits/Services is also satisfied. These rules are outlined in the Chart of ERISA and SBC Requirements below.

Chart of ERISA and SBC Requirements

ERISA Requirements		SBC Requirement
Summary of Material Modification (SMM)	**Notice of Reduction in Benefits/Services**	**SBC Modifications**
Must be provided upon any material modification to the plan and any change in the information required to be in the SPD.	Same requirements as SMM, except that expedited requirements apply upon a material reduction in covered benefits or services.	Must be provided when there is a material modification of plan terms or coverage that is not reflected in the most recently provided SBC.
Must be written in plain language so that the average plan participant can understand (no model notice available).	Must be written in plain language so that the average plan participant can understand (no model notice available).	May be provided through a separate SMM notice or through an updated SBC.
Must be provided within 210 days of the end of the plan year in which the modification is adopted.	Must be provided within 60 days after the material reduction in covered benefits or services is adopted.	Must be provided at least 60 days before the modification becomes effective.
Any SMMs that are not yet included in the SPD must be distributed along with the SPD until a revised SPD is distributed.	Any SMMs that are not yet included in the SPD must be distributed along with the SPD until a revised SPD is distributed.	Complying with this SBC Modification requirement will satisfy the existing ERISA requirement to provide an SMM or Notice of Reduction in Benefits/Services.

Uniform Glossary

In addition to including a uniform glossary in the SBC itself, plans and insurers must make a uniform glossary available to participants and beneficiaries in either paper or electronic form. The uniform glossary may not be modified and must be provided upon request by a participant or beneficiary within seven business days.

Coverage Offered Outside the US

For plans that provide coverage outside the US (i.e., expatriate coverage), plans and insurers may offer an internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the US, rather than distributing SBCs to plan participants and beneficiaries.

SBC DELIVERY

Plan administrators of both self-insured and fully insured group health plans must ensure that SBCs are distributed to participants and beneficiaries at certain required intervals during the employment cycle as described in greater detail in the SBC to Participants and Beneficiaries sub-section below. In the context of employee benefit plans, the definition of "participant" includes any current or former employee who is or may become eligible to receive a benefit from an employee benefit plan. The definition of "benficiary" includes any person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit.

In addition, SBCs must be provided by health insurers to plan sponsors of fully insured plans at certain required intervals in the contract renewal cycle as described in greater detail in the SBC to Plan Sponsors sub-section below.

SBC to Participants and Beneficiaries

The plan administrator of a group health plan is generally responsible for providing the SBC to plan participants and beneficiaries for each benefit package under the plan. For fully insured plans, the insurer is equally responsible for providing the SBC, and the SBC delivery requirement is generally satisfied as long as the SBC includes the required content and is provided by any entity within the required time frame. As a practical matter, however, plan sponsors of both fully insured and self-insured plans are encouraged to take direct responsibility for providing the SBC to participants and beneficiaries, even at risk of duplicated efforts, to avoid compliance failures stemming from miscommunication with the insurer.

The SBC must be provided to participants and beneficiaries at the following times:

- Upon eligibility for the health plan (by the first day on which the employee is eligible to enroll for coverage under the plan)

- At initial/mid-year enrollment (if due to HIPAA special enrollment rights, no later than 90 days from enrollment)
- At annual open enrollment (generally by no later than 30 days prior to the first day of the new policy year)
- Upon employer-initiated mid-plan year change (at least 60 days in advance of the effective date of any material change in benefits that affects the SBC content, such as increases in cost-sharing or additional coverage limitations)
- Upon request (within seven business days of the request)

Employers may provide a single SBC to a participant and to any beneficiaries at the participant's last known address, except that a separate SBC must be provided to a beneficiary if the family member is known to live at a different address. Also note that a separate SBC must be provided to a beneficiary if the beneficiary enrolls in coverage separately from the employee, such as when an enrolled employee later exercises a HIPAA special enrollment right to add a new spouse as of a midyear effective date.

The SBC can be distributed as a stand-alone document or in combination with the SPD, provided the SBC is prominently displayed early in the SPD's provisions, directly after the SPD table of contents, and provided the SBC is distributed in a timely manner. Importantly, though, since the SBC must be distributed more often than the SPD, and the SBC must be delivered to participants and beneficiaries (whereas the SPD only needs to go to participants), there may be additional challenges with attaching the SBC to the SPD.

Employers may distribute SBCs by hand, by mail, or by electronic delivery (email) in a manner that complies with the DOL's electronic disclosure safe harbor. In general, employers must "use measures reasonably calculated to ensure actual receipt of the material by plan participants, beneficiaries and other specified individuals." The DOL's safe harbor rules allow for electronic distribution to employees who have computer access as an integral part of their job (work email address, regular access to laptop/phone or other devices). Employees without computer access as an integral part of their job must consent to electronic distribution of notices (usually using a personal email address). While electronic delivery can include posting to an employer's intranet or benefits portal or sending via email (among other electronic means), these measures alone do not satisfy the DOL's distribution requirements. Employers must also notify employees that the notice has been posted and must describe the significance of the notice and the employee's right to request a paper copy.

For eligible participants and beneficiaries who are not yet enrolled in coverage, the SBC may be delivered electronically if the format is readily accessible, the SBC is provided in paper (free of charge) upon request, and (in the case of an internet posting of the SBC) the plan or issuer timely notifies the individual (by paper or email) of the SBC's availability on the internet and in paper form.

Importantly, employers should routinely document all methods of delivery used for the SBC (and for all other required notices) and should retain these records in accordance with the employer's record retention policy. In general, records related to ERISA plans should be retained for eight years. For more detailed information about electronic distribution rules, including a **Sample Employee Communication** and a **Sample Employee Consent to Receive Plan Disclosures**, see the PPI publication **Electronic Distribution Rules: A Guide for Employers**.

SBC to Plan Sponsors

For fully insured group health plans (but not also for self-insured plans), insurers are required to provide SBCs to plan sponsors at the following times:

- Upon initial application (as soon as practical, but no later than seven days following receipt of an application for group health coverage from a plan sponsor)
- Upon renewal, if the insurer renews or reissues the policy, certificate or contract of insurance (by no later than 30 days prior to the first day of the new plan year for automatic renewals; by the date the written application materials are due for non-automatic renewals)
- Upon request (within seven business days of the request)

Employers should consult with insurers and third-party administrators as needed regarding preparation and distribution of SBCs to ensure that the obligations and responsibilities of all parties are timely met.

PENALTIES

The penalties associated with noncompliance with SBC distribution requirements are significant. Specifically, a group health plan or insurance carrier that willfully fails to provide the SBC to a participant or beneficiary is subject to a fine of up to $1,362 per participant or beneficiary (as of 1/15/2023, adjusted annually for inflation). In addition, such plans or carriers may also need to self-report noncompliance on Form 8928 and pay an excise tax to the IRS of $100 per day per individual (not subject to annual inflation adjustment) for each day that the plan fails to comply with the requirement.

SUMMARY

Employers that sponsor group health plans should review the SBC requirement and all related guidance and should work with insurance carriers and third-party administrators to provide the SBCs, uniform glossary and any material modification notices timely. Employers should pay special attention to open enrollment and plan year start dates in order to satisfy the SBC distribution requirements.

RESOURCES

SBC Final Regulations

SBC Instructions for Group Coverage

SBC Template

SBC Guidance for Compliance

Sample Completed SBC

Sample Language for SBC "Why This Matters" Section (for "Yes" Answers)

Sample Language for SBC "Why This Matters" Section (for "No" Answers)

Uniform Glossary

Coverage Example (Diabetes Narrative)

Coverage Example (Diabetes Scenario)

Coverage Example (Maternity Narrative)

Coverage Example (Maternity Scenario)

Coverage Example (Simple Foot Fracture Narrative)

Coverage Example (Simple Foot Fracture Scenario)

Table of County Populations for "Culturally and Linguistically Appropriate" Requirement (Pages 14-17)

PPI BENEFIT SOLUTIONS