# Employer Guide to the Summary of Benefits and Coverage (SBC)

Edward Fensholt, Rory Kane Akers and Ethan McWilliams
*Lockton Benefit Group—Compliance Services*

Updated 2017

LOCKTON

PAGE

# PART I: AN OVERVIEW OF THE SBC REQUIREMENT

## A. Background

The Patient Protection and Affordable Care Act (ACA) expands ERISA's disclosure requirements by requiring that a summary of benefits and coverage (SBC) be provided free of charge to employees eligible for coverage prior to enrollment or re-enrollment. The SBC rules also apply to plans not subject to ERISA, such as state and local governmental plans, and plans maintained by churches. The summary must accurately describe the "benefits and coverage under the applicable plan or coverage." ERISA plans must comply with the SBC requirement in addition to ERISA's Summary Plan Description and Summary of Material Modifications/Summary of Material Reductions disclosure requirements. Significant penalties—$1,105 per violation—may be imposed for failing to comply with the SBC rules.

The SBC must:

- Not exceed four double-sided pages,
- Be provided to participants free of charge, and
- Precisely honor specific language and formatting requirements—all symbols, bolding, colors and shading, as well as wording, must be duplicated exactly, with limited exceptions. SBC templates and instructions issued by federal regulatory agencies are very detailed, and in most cases, the suggested language must be used.

To the extent a plan's terms are difficult to summarize in an SBC in accordance with the SBC template instructions, the template should be completed in a manner that is as consistent with the instructions as possible. This may occur, for example, if a plan provides:

- A different structure for provider network tiers or drug tiers than is represented in the SBC template,
- Different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient),
- For potential reimbursement of out-of-pocket expenses, like deductibles, through a health flexible spending account (health FSA) or health reimbursement arrangement (HRA), or
- Different cost-sharing based on participation in a wellness program.

## B. Which Plans Must Be Summarized in an SBC?

The requirement to distribute SBCs applies to all group health plans *subject to the ACA*. The requirement therefore applies to insured and self-insured health plans subject to the ACA. A plan's "grandfathered" status under the ACA is irrelevant.

But some health-related plans and health care expense reimbursement programs dodge—or can dodge—the SBC requirement because they're not subject to reform or some other exception

applies. Here's a list of common health-related plans and programs, and a description of the extent to which the SBC rules apply to them:

***Dental and Vision Plans:*** Limited scope dental and vision plans are not required to comply. If medical benefits are bundled with dental and/or vision coverage (i.e., the dental and/or vision coverage is provided under the same contract as medical *or* the dental/vision coverage is self-insured), the SBC requirements apply to the dental/vision coverage unless participants can opt-out of the dental/vision coverage, *or* claims for the dental/vision benefits are administered under a contract separate from the contract under which medical claims are administered.

***Health Flexible Spending Accounts (Health FSAs):*** Health flexible spending accounts are not required to comply as long as they're considered an "excepted benefit" under health reform.[1] Although health FSAs typically are not subject to the SBC requirements, a plan sponsor may choose to reference its health FSA—and the fact that the dollars available from the FSA may be used to satisfy deductibles and other out-of-pocket expenses under the medical plan—in the comprehensive medical plan's SBC.

***Health Savings Accounts (HSAs)***: Health Savings Accounts are not considered health plans, so there is no requirement to supply an SBC with respect to an HSA. Note, however, that some people confuse the literal HSA with the companion high deductible health plan (HDHP), sometimes referring to the latter as an "HSA plan." The HDHP is subject to the SBC rules. Although HSAs are not subject to the SBC requirements, a plan sponsor may reference an HSA program—and the fact that the dollars available from an HSA may be used to satisfy deductibles and other out-of-pocket expenses under the HDHP medical plan—in the comprehensive medical plan's SBC.

***Employee Assistance Programs (EAPs):*** These *appear* to be subject to the SBC requirements, where they supply counseling (medical care) as opposed to merely referrals. Where the EAP is bundled with (that is, considered part of, and reflected in the Form 5500 for) the health plan, the health plan's SBC may refer to the EAP, or may be modified to refer to the EAP.

Where it's not bundled—where the EAP is a stand-alone ERISA plan, for example—federal authorities will likely expect the sponsor or carrier to supply an SBC. For those EAPs subject to the SBC requirement, one challenge is that a description of EAP benefits simply doesn't fit very well into the federal model SBC template. Regulators say the EAP plan sponsor or insurer should use "best efforts" to accurately describe the relevant terms of the EAP benefit in a manner that is consistent with the instructions and the template.

***Health Reimbursement Arrangements (HRAs):*** Health reimbursement arrangements (HRAs) will usually be subject to the SBC requirements. However, often HRAs are integrated with major medical coverage, and federal authorities allow that such an integrated HRA's benefit

[1] This will be the case unless the health FSA supplies significant employer contributions (at least $500 per year) or is available to employees who are not also offered comprehensive medical coverage.

can be alluded to or otherwise described somehow in the major medical plan's SBC, as potentially reducing the insured's out-of-pocket expense exposure.

Where the HRA is *not* integrated with the major medical coverage—where it is a stand-alone reimbursement program that may be used to offset major medical plan deductibles, etc. and also to reimburse out-of-pocket expenses not covered by the major medical plan—in theory it should have its own SBC. There's not a good or easy answer to this dilemma either, as the SBC templates were not prepared with HRAs in mind. "Do your best" is what the federal authorities say in such a case. See also the discussion on the following page regarding retiree-only plans as exempt from the SBC rules. Thus, a retiree-only HRA, operating as a separate plan, would not be subject to the SBC requirements.

***Wellness Programs:*** Where a wellness program is offered as part of the major medical plan, and could affect a participant's cost-sharing under the plan (for example, because the wellness program provides credits towards deductibles, copays or coinsurance), the coverage examples in the SBC for the major medical plan should note the effect of the wellness program when discussing the assumptions used in creating the examples. Note the SBC coverage examples are not required to reflect *premium* discounts or surcharges on account of a wellness program. Federal authorities' model completed SBC template reflects, on the last page, how a wellness program might affect an insured's cost-sharing obligations.

***Expatriate Plans:*** These pose unique issues. Federal authorities recognize that expatriate coverage carries additional administrative costs and barriers in compiling SBCs. Therefore, instead of summarizing coverage for items and services provided outside the U.S., a plan may provide an internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. If the plan provides coverage *within* the U.S., the plan is still required to provide an SBC that accurately summarizes benefits and coverage available within the U.S.

***Long-Term Care Plans:*** Although contemporary long-term care plans typically supply some form of medical benefit, they are "excepted benefits" under the ACA, and thus not subject to the SBC requirements, when they are offered under a separate insurance contract, which is usually the case.

***Retiree-Only Plans:*** Retiree-only plans—whether benefitting pre-65 or post-65 retirees, or both—dodge the SBC requirement because they are treated as "excepted benefits," and thus are not subject to the SBC requirements, due to the fact that they don't cover at least two active employees.

***Insured Plans No Longer Actively Marketed:*** Sometimes an insurer providing fully-insured group coverage to an employer stops offering to the marketplace the same insurance contract held by the employer. Federal authorities have given these insurers a one-year reprieve from the SBC rules, with respect to these fully-insured plans that are no longer actively marketed.

***On-Site Clinics:*** On-site clinics appear to be "excepted benefits" for purposes of the SBC rules (and much of the rest of the ACA) and therefore are not subject to the SBC requirements.

## C. Who Must Provide the SBC . . . the Insurer or the Plan Sponsor?

For self-insured plans, the "plan administrator" must supply the SBC. That's usually the employer/plan sponsor. If you're not sure who the plan administrator is (this is a term of art, by the way; it doesn't mean the third-party *claims* administrator or claims payor, usually), check the plan's summary plan description (SPD). The SPD usually lists the plan administrator in the SPD's "General Provisions" or under a similar title or heading.

For *insured* plans, the rules require the insurer or the plan administrator to supply the SBC. This means that if the insurer fails to supply the SBC, the plan administrator/plan sponsor will have to do so, or risk penalties. If the insurer provides an SBC that is both timely and compliant, the plan administrator's obligation is satisfied.

What happens if an insurer or other third party agrees to timely supply a compliant SBC to the plan's enrollees and others, but fails to do so? Federal authorities say they normally won't take action against the plan administrator/plan sponsor in such a case, if:

- The plan administrator/plan sponsor enters into a binding contractual agreement under which the third party assumes responsibility to: (1) complete the SBC; (2) provide required information to complete a portion of the SBC; or (3) deliver the SBC; and
- The plan administrator/plan sponsor monitors the third party's performance under the contract; and
- The plan administrator/plan sponsor promptly corrects a violation of the SBC rules once it has knowledge of the violation and the information to correct it (if the plan administrator/plan sponsor has knowledge of a violation and does not have the information to correct it, it must communicate with participants and beneficiaries regarding the violation and begin taking "significant steps" as soon as practicable to avoid future violations).

> ***Recommendation:*** *These requirements may be a bit challenging to satisfy. If the insurer informs an employer that it (the insurer) intends to distribute an SBC to plan participants and to make the SBC available to individuals eligible for coverage but not enrolled, it would be best if the employer had this commitment in writing—if only in an e-mail—and ensure the commitment reflects the date by which the insurer will do so (and of course that date should be consistent with the SBC requirements).*
>
> *Ideally, the agreement should include the employer's right to indemnification if the insurer fails to timely distribute the SBCs to all people entitled to receive them, or fails to prepare an SBC that complies with all the instructions. However, it may be difficult to obtain such indemnification as a practical matter.*

In subsection D, below, we may refer to "the plan" as supplying the SBC. When we make such a reference, we mean the insurer or plan administrator/plan sponsor, as the case may be.

## D. Delivery: How and When Must an SBC be Supplied, and to Whom?

The rules concerning how and when the SBC must be provided differ depending on whether:

- The individual is *enrolled* in coverage, or merely *eligible* for coverage but not enrolled;
- The individual's enrollment occurs *during* open enrollment, or *later* (such as during a special enrollment opportunity);
- The enrollment occurs *online*, or in *other ways* (e.g., on paper); and
- With respect to individuals who are already enrolled in coverage, their re-enrollment occurs *automatically* without opportunity to change coverage options, or (instead) they must either affirmatively re-enroll each year or their re-enrollment is automatic but they have an option during open enrollment to change coverage options.

> ***Lockton comment:*** *One of the most potentially confusing aspects of the SBC delivery rules concerns just how an SBC is "provided." The rules require a plan to "provide" an SBC at a variety of times. Sometimes to "provide" an SBC means to literally give it to the individual, but at other times it simply means to make it available, which may occur electronically such as via email or via Internet posting.*

The delivery rules are summarized in the grid attached as Appendix A. A more detailed, narrative description appears below.

### Current Enrollees Affirmatively Re-Enrolling, or Enrollees Whose Re-Enrollment is Evergreen but Who May Affirmatively Change Coverage Elections during Open Enrollment

For current enrollees who:

1. Must affirmatively re-enroll (that is, current enrollees who must sign up for coverage each year or their old coverage election lapses and they're treated as not having elected coverage for the new year), or

2. May choose to do nothing and be automatically re-enrolled in their existing coverage option for the year, but who may also choose to affirmatively change coverage elections during open enrollment,

the plan should have the SBCs prepared and ready by the first day of the open enrollment period. The plan has an affirmative obligation to deliver to the current enrollee the SBC *for the option in which the enrollee is currently enrolled* (we presume the obligation is to supply an SBC reflecting changes to that option for the upcoming year).

> ***Lockton comment:*** *If there are other plans or coverage options, reflected in separate SBCs, for which the enrollee is eligible but in which he or she is not enrolled, it appears those SBCs should be made available as described below, under the heading, Individuals Eligible but Not Enrolled, Who May Enroll During Open Enrollment.*

If the updated version of the SBC for the coming new plan year is not yet prepared by the time open enrollment comes around, the plan should supply the *current* year's version of the SBC, and then provide the updated version prior to the first day of the coming new plan year.

The SBC should be included with open enrollment materials. If open enrollment occurs *online* (electronically), the SBC may be provided as part of the online enrollment process (presumably an electronic version of the SBC that the enrollee may view and print, or a downloadable version that the enrollee may download and print).

There's little detailed guidance on *how* the SBC may be provided electronically, where open enrollment occurs electronically. May the SBC be sent via an email, where employees actually accomplish enrollment through some other electronic portal? Is it adequate to simply post a link to the SBC on the electronic portal the employee must enter to enroll or re-enroll? Presumably, both of these methods would be acceptable.[2] If the participant requests a paper copy of the SBC, however, the plan must honor that request.

If the re-enrollment does ***not*** occur online, the insurer or plan administrator may include a paper version of the SBC with the paper enrollment packet, or may deliver the SBC electronically. But in this latter case the rules governing electronic distribution are more challenging. The plan must comply with ERISA's rules governing electronic delivery of required notices. Those rules essentially require that the recipient either have access to the employer's electronic network as an integral part of his or her duties, or the plan must obtain the recipient's consent to receive the SBC electronically. The consent may be obtained by sending the individual an email, and allowing the individual to "consent" to the electronic distribution by clicking on a link to the SBC. Presumably, the employer's network would be able to record the email addresses from which online SBCs were accessed. See Appendix B for a discussion of the Labor Department rules that apply in this case.

This "consent" requirement may prove particularly challenging when the plan must supply an SBC to a non-employee, such as a COBRA beneficiary, for whom the plan may not have a valid email address.

> ***Recommendation:*** *As a practical matter, where the plan conducts enrollment on paper and the employee has dependents on the plan, the open enrollment materials (including the SBC) should probably be mailed to the employee's home, addressed to the employee and family. If the re-enrollment occurs on paper and the employee has merely "employee-only" coverage, the enrollment materials (including the SBC) may be hand-delivered, mailed or sent electronically, but if sent electronically, it appears the delivery must comply with the Labor Department's detailed rules for electronic delivery, as described above.*

---

[2] Federal authorities merely say that the SBC may be provided electronically "in connection with" an online open enrollment process.

However the plan provides the SBC, according to an FAQ issued by federal authorities, the furnishing of an SBC to the participant (i.e., the covered employee) is deemed to accomplish delivery to covered dependents, unless an enrolled dependent has a last known address different from the participant's. In that event, a separate SBC must be provided to the dependent at his or her last known address.

> ***Recommendation:*** *Plan sponsors may wish to add language to enrollment forms whereby enrolling employees acknowledge that where the plan supplies an SBC to a participant, the provision of the SBC to the participant will be deemed to accomplish delivery of the SBC to his or her dependents unless the participant notifies the plan that a dependent resides elsewhere.*

There's more information, concerning flexibility under the rigid SBC formatting rules for electronically-displayed SBCs (displayed on a webpage, for example) in the discussion under subsection F below.

### Current Enrollees Whose Re-Enrollment Occurs Automatically Without Opportunity to Change Coverage Options

For current enrollees whose re-enrollment occurs automatically (and where there is no opportunity to change coverage options during open enrollment), the deadline for actually providing the SBC can be later.

> ***Lockton comment:*** *It's not entirely clear whether this rule applies to currently enrolled participants whose re-enrollments are "evergreen," where there is only one coverage option, and the participant may choose to affirmatively dis-enroll, but we presume that's the case.*

The SBC must be provided not fewer than 30 days prior to the plan's new plan year. There's an exception (in the case of insured plans) where the renewal is not finalized or the carrier has not committed to the renewal by that 30-day deadline. In that case, the SBC should be provided as soon as reasonably possible, but not later than seven business days after the insurer issues the renewed policy or supplies written confirmation of intent to renew, whichever is earlier. The plan satisfies the "seven business day" rule if it *sends* the SBC within seven business days.

The plan has an affirmative obligation to deliver to the current enrollee the SBC for the option the enrollee is *currently* enrolled in (we presume the obligation is to supply an SBC for that option, reflecting changes to that option for the upcoming year). If the updated version of the SBC for the coming new plan year is not yet prepared, the plan should supply the current year's version of the SBC, and then provide the updated version prior to the first day of the coming new plan year.

If the plan's open enrollment process occurs electronically, it appears the SBC may be provided as part of the online enrollment process (i.e., an electronic version of the SBC that the enrollee may view and print, or a downloadable version that the enrollee may download and print). Again, there's little detailed guidance on how the SBC may be provided electronically where open enrollment occurs electronically. May the SBC be sent via an email, where employees

actually accomplish enrollment through some other electronic portal? We assume so.[3] If the participant requests a paper copy of the SBC, however, the plan must honor that request.

But perhaps the safest play—and the *required* method where enrollment does not occur online—is to deliver a paper copy of the SBC, or (apparently) deliver the SBC electronically in accordance with the more burdensome ERISA's rules governing electronic delivery of required notices. Those rules essentially require that the recipient either have access to the employer's electronic network as an integral part of his or her duties, or the plan must obtain the recipient's consent to receive the SBC electronically. This "consent" requirement will prove challenging when the plan must supply an SBC to a non-employee. See Appendix B for a discussion of the Labor Department rules that apply in this case.

As a practical matter, where the employee has dependents on the plan, the best course may be to mail the SBC to the employee's home, addressed to the employee and family, because delivering the SBC to the employee in this fashion is also deemed to accomplish delivery to the dependents unless an enrolled dependent has a last known address different from the participant's. In that event, a separate SBC must be provided to the dependent at his or her last known address.

If the employee has merely "employee-only" coverage, the SBC may be hand-delivered, mailed, or sent electronically. If sent electronically, the safe course is to ensure delivery complies with the Labor Department's detailed rules for electronic delivery, described in Appendix B.

### Individuals Eligible but Not Enrolled, Who May Enroll During Open Enrollment

For individuals who are not enrolled but are eligible to enroll in coverage, the manner in which the SBCs are "provided" to these individuals can differ. That is, it appears the plan does not necessarily have an *affirmative* obligation to *deliver* the SBCs to these individuals who are merely eligible, and not already enrolled, as long it makes the SBCS available online.. The plan should make the SBCs available no later than the first day the person may enroll.

Where the plan intends to make the SBCs available electronically, it may do so via email or Internet posting. If via Internet posting, the must plan to satisfy certain requirements:

- The SBC must be in a readily accessible format (such as in an html, MS Word, or pdf format);
- The SBC must be provided in paper form free of charge upon request; and
- The plan must timely advise its participants and beneficiaries that the SBC is available on the web and provide the web address. Plans may make this disclosure (sometimes referred to as the "e-card" or "postcard" requirement) by email, but unless the participant accesses the

[3] Federal authorities merely say that the SBC may be provided electronically "in connection with" an online open enrollment process.

employer's electronic data system at the workplace or unless the employer has a valid email address for the participant, the more prudent play may be to send the card by regular mail.[4]

Federal authorities have offered the following model language for the "postcard" supplied to eligible individuals, alerting them to the availability of SBCs on an Internet site:

**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).

Interestingly, when the SBCs are made available electronically, there is not a requirement that, once the eligible individual actually enrolls, the plan reach back out to him or her and supply him or her with the SBC for the actual coverage option in which he or she enrolled (unless he or she requests another copy). That affirmative obligation won't arise until the next open enrollment period, when the newly enrolled person will then have the status of someone already enrolled.

## Individuals Eligible but Not Enrolled, Who May Enroll Outside of Open Enrollment (e.g., Initial Enrollment, Special Enrollment)

Some eligible but not currently enrolled individuals may enroll outside of the plan's open enrollment period. These include individuals who enroll upon becoming eligible mid-year (say, upon hire or transfer to an eligible class of employees) and those who enroll during a HIPAA special enrollment window, such as where the individual marries or experiences the birth or adoption of a child, or loss of coverage elsewhere.

---

[4] May the SBC be provided electronically via *Intra*net site, rather than Internet site? In the actual SBC regulations, federal authorities, when discussing the shortcuts for supplying SBCs to individuals who are eligible for coverage but not enrolled, refer to providing the SBC "electronically (*such as* by email or an Internet posting)..." The use of "such as" suggests that other methods may be appropriate too, as long as they are "readily accessible" to the individuals.

If the plan is able to post its SBCs on an Internet site and refer to that site in the notice, this would surely satisfy the requirement (the SBC rules were written with insurance companies mostly in mind, hence the desire to have the SBCs available on an Internet site). Whether listing an *Intranet* site in the notice is adequate is not entirely clear, but we think it should be considered adequate by federal regulators as long as posting there makes the SBCs "readily accessible" to the intended audience.

These eligible individuals must, while they're eligible, have access to the SBC for each coverage option in which they may enroll. The plan should make the SBCs available no later than the first day the person may enroll (i.e., the first day they become eligible).

Just as described in the preceding section of this *Guide*, the SBCs may be made available electronically such as via email or Internet posting if the plan satisfies certain requirements:

- The document must be in a readily accessible format (such as in an html, MS Word, or pdf format);
- The SBC must be provided in paper form free of charge upon request; and
- The plan must timely advise its participants and beneficiaries that the SBC is available on the web and provide the web address. Plans may make this disclosure (sometimes referred to as the "e-card" or "postcard" requirement) by e-mail, but unless the participant accesses the employer's electronic data system at the workplace or unless the employer has a valid email address for the participant, the more prudent play may be to send the card by regular mail.

Federal authorities have offered model language for the "postcard" supplied to eligible individuals. See the model language above in the section dealing with eligible individuals who enroll during an open enrollment period. See also footnote 4, which addresses the question whether posting SBCs on an *Intra*net site may be considered adequate.

What happens when the person actually enrolls? If the enrollment occurs other than during a HIPAA special enrollment period, the plan's obligation is no different than when an eligible individual first enrolls during open enrollment: There is no duty to affirmatively reach out to the individual and deliver the SBC for the option in which he or she has just enrolled, unless he or she requests the SBC.

But oddly, that's not the rule where the enrollment occurs during a HIPAA special enrollment period. In that case, the plan must affirmatively supply to the enrollee the SBC for the coverage option in which he or she enrolled, and must do so ***within 90 days after the special enrollment.*** Remember that HIPAA special enrollments may arise where an employee marries, or experiences the birth or adoption (or placement for adoption) of a child; where an employee or dependent loses Medicaid or CHIP coverage or premium payment assistance under Medicaid or CHIP; or where an employee or dependent loses coverage elsewhere for certain reasons, such as loss of eligibility or exhaustion of COBRA coverage.

## Individuals Who Request an SBC

The plan must provide the requested SBC(s) as soon as practicable, but *no later than seven business days* after the request. Federal authorities say that a plan meets this deadline if it sends the SBC within seven business days. If the individual requests an SBC online, the SBC may be provided electronically.

### COBRA Beneficiaries

The federal rules are clear that COBRA beneficiaries are entitled to receive an SBC during the plan's open enrollment periods, too (remember that COBRA beneficiaries have the same rights as active employees to change coverage options, etc., during an open enrollment period). Most plans don't require the COBRA beneficiary to affirmatively re-enroll during an open enrollment period, but permit COBRA beneficiaries to change coverage elections, if multiple coverage options are available. Thus, the plan should supply the SBC to COBRA beneficiaries during the open enrollment period. The better play here is probably to mail the SBC to the COBRA beneficiary's last known address.

### Children Covered Under a Qualified Medical Child Support Order

Children who are covered under a plan pursuant to a qualified medical child support order should, we believe, be treated like an enrolling or re-enrolling employee. The better play here is probably to send the SBC to the child's home, addressed to the child, or to the adult caring for the child (e.g., "in care of" the child).

## E. When is an SBC Updated?

Plans must distribute an *updated* SBC at different times.

If the plan supplied an SBC to an individual during the enrollment process, but before the first day of coverage there is any change in the information required to be in the SBC, the plan must update and provide a current SBC no later than the first day of coverage. This may occur more frequently than you think. It may often be the case that by the time open enrollment commences, an updated (for the new plan year) SBC is not ready; in that case the plan will have to timely supply the current version of the SBC, but then supplement it with the new version of the SBC prior to the first day of the year.

In addition, if *during the plan year* the plan is materially amended in such a way that the information required to be in the SBC changes, the plan must supply an updated SBC or at least a notice of the change at least 60 days *in advance of the effective date of the change*. A "material" amendment is one that would be considered important by an average plan participant.

Happily, the final SBC regulations say the new 60-day rule does not apply to changes made at *renewal*. But the timing rules for distributions of SBCs at open enrollment don't do plan sponsors any favors either, and in some cases may require notice more than 60 days prior to the beginning of the plan year.

> ***Lockton comment:*** *This obligation to supply notice of mid-year changes is a substantial acceleration of the deadline for supplying notice of material plan changes under current ERISA rules. Under ERISA guidelines, ERISA plans must distribute a notice of material modification within seven months after the close of the year in which the change is made, unless the change is a material reduction in benefits. In that case the notice must be supplied within 60 days after the change is adopted. As noted*

*above, an updated SBC—or a notice of a change to the SBC (the notice must honor the style and format requirements of the SBC)—must be supplied not fewer than 60 days before the effective date of the change.*

The notice of a mid-year change must be in writing, but may be supplied electronically in accordance with Department of Labor rules for providing electronic notice. As described in additional detail above, on page 6, those rules essentially require that the recipient either have access to the employer's electronic network as an integral part of his or her duties, or the plan must obtain the recipient's consent to receive the SBC electronically.

## F. What Must the SBC Contain, Generally?

Federal authorities have issued detailed guidance on what information an SBC must contain. In Part II of this *Guide* we include a link to that detailed guidance, but here's a quick overview of the requirements, and some pragmatic nuts and bolts.

### An Overview of the Content Requirements

The Labor Department's final SBC regulations and current SBC template require the SBC to contain:

- A description of the coverage, including cost-sharing (deductibles, co-pays, coinsurance), as well as exceptions, reductions, and limitations of the coverage.
- An Internet address where the SBC may be obtained.
- Continuation of coverage provisions.
- Examples of coverage (the rules permit federal authorities to prescribe up to six examples, but the current template includes three, one each for maternity expenses, managing diabetes, and a simple fracture).
- A statement that the SBC is only a summary and that the plan documents should be consulted to determine the governing contractual provisions of the coverage.
- A telephone number and Internet address for questions and how to obtain a copy of the plan document or the insurance contract, policy, or certificate.[5]
- An Internet address[5] for obtaining a list of network providers and the prescription drug formulary.
- A statement about whether the plan provides "minimum essential coverage" for purposes of satisfying the ACA's individual health insurance mandate, and whether it provides "minimum value" under the ACA (e.g., coverage with at least 60 percent actuarial value).

[5] Will an *Intra*net address suffice? It's not clear that it does, but we assume that it does, at least with respect to individuals who have ready access to the Intranet site.

The language should make clear that coverage that does not supply minimum value may render the individual eligible for subsidies toward the purchase of individual market coverage. In addition, the language should indicate the potential adverse tax consequences for not maintaining minimum essential coverage.

- For plans that contain a network of healthcare providers or drug benefit, an Internet address or similar contract information for obtaining a list of the network providers or more information about the prescription drug benefit.
- An Internet address for obtaining the federal authorities' Uniform Glossary of Health Coverage and Medical Terms, a statement that paper copies of the Glossary are available, and a phone number to call, to obtain a paper copy.

## Model Documents

Federal authorities have posted updated versions of **instructions** for appropriately constructing an SBC, a **model completed SBC**, an **SBC template** and a model Uniform Glossary (the updated versions are labeled "released on April 6, 2016," in the lower right corner of the first page). They are available here:

https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Summary of Benefits and Coverage and Uniform Glossary

These documents include versions in English, Spanish, Chinese, Tagalog, and Navajo, and replace the prior versions issued in August of 2013.

The new documents contain various revisions and modifications to the prior documents, including some substantive changes as well as formatting changes. Some of the substantive changes include:

- A new question identifying any services covered before the deductible is met.
- A new instruction requiring the use of specific language to identify whether the plan has "embedded" or "non-embedded" deductibles or out-of-pocket maximums.
- A new instruction requiring the use of specific language to identify whether the plan uses a tiered network to alert participants that costs for in-network services may vary depending on the tier of the physician or facility.
- A new instruction requiring a list of certain "core" limitations, including when cost-sharing for in-network services does not count toward the out-of-pocket limit, prior authorization requirements, visit limits, or exclusion of a particular service category or substantial part of a service category.
- A new coverage example for a simple fracture treated in the emergency room.
- A requirement that terms defined in the Uniform Glossary be underlined in the SBC. The underlined term may also be hyperlinked to the federal authorities' online Uniform Glossary.

## Culturally and Linguistically Appropriate Standard (CLAS)

Plans must provide SBCs in a "culturally and linguistically appropriate manner." If a participant resides in a county in which 10 percent or more of the population (according to the most recent census) is literate in the same non-English language, an offer (in that language) of oral translation assistance, and an offer to supply the SBC in that foreign language, must appear in a prominent place in the SBC. Federal authorities recommend the notice appear on the page of the SBC on which the "Your Rights to Continue Coverage" and "Your Grievance and Appeals Rights" sections appear.

Appendix C includes a link to the list of relevant counties, and model notice text—in Spanish, Chinese, Tagalog, and Navajo—that plans may use to satisfy the culturally and linguistically appropriate notice requirement. Model SBCs and glossaries in Spanish, Chinese, Tagalog and Navajo are also available at the **link** listed above, under *Model Documents*.

> ***Recommendation:*** *Where a plan must include a translation assistance notice, in a foreign language, in a prominent place on an individual's SBC, it's probably easiest to simply include the notice on all SBCs. For example, if an employer has 500 employees, and 250 reside in a county subject to the CLAS requirement, and 250 employees in an adjacent county that is not subject to CLAS, it's nevertheless probably easiest to simply print the required CLAS notice on all the SBCs issued by the plan.*

## Rigid Formatting Rules…but Some Exceptions, Particularly for Electronic SBCs

As noted earlier, federal regulations don't allow variations in style or formatting of a plan's SBC, with very limited exceptions (even font size is mandated).

One significant but limited formatting exception concerns electronically displayed SBCs, such as a plan sponsor may display on an Internet or Intranet page. Federal regulators permit minor adjustments to an SBC's formatting to accommodate the plan's information and electronic display method, such as expansion of columns. Additionally, it is permissible to display the SBC electronically on a single webpage, so the viewer can scroll through the information required to be in the SBC without having to advance through pages (as long as a printed version is available that meets the formatting requirements of the SBC). However, the deletion of columns or rows is not permitted when displaying a complete SBC.

In addition, plans may display SBCs, or parts of SBCs, in a way that facilitates comparisons of different benefit package options by individuals considering their coverage choices. For example, on a website, viewers could be allowed to select a comparison of only the deductibles, out-of-pocket limits, or other cost sharing of several benefit package options. This could be achieved by providing the "deductible row" of the SBC for several benefit packages, but without having to repeat the first one or two columns, as appropriate, of the SBC for each of the benefit packages.

However, such a chart, website, or other comparison does not, itself, satisfy the requirements to provide the SBC. The full SBC for all the benefit options included in the comparison view/tool must be made available in accordance with the regulations and other guidance.

## Describing a Plan's Benefit Packages in a Single SBC, or Separate SBCs

The final regulations state that a plan utilizing two or more benefit packages (such as a major medical component and a health reimbursement arrangement, or HRA) may combine the information into a single SBC, or issue separate SBCs.

For the first two years the SBC requirement was in effect, federal authorities permitted a plan that uses *two or more insurers* to provide *multiple partial* SBCs that, together, provide all the relevant information to meet the SBC content requirements. This option does not appear to be available any longer.

## Expressing Carve-Out Arrangements in a Plan's SBC

Where a health plan utilizes "carve-out arrangements" (such as pharmacy benefit managers and managed behavioral health organizations) to help manage certain benefits, federal authorities expect the party responsible for issuing the SBC (i.e., the major medical insurer or the self-insured plan sponsor) to make an effort to include all relevant information in the plan's SBC, even though the authorities recognize some of the required information may be in the hands of other parties.

A special temporary rule allows plans that use insurers to supply some benefits under a single plan to actually issue multiple partial SBCs that, taken together, satisfy all the SBC requirements. That is, due to the administrative challenges of combining benefit information related to benefits supplied by different vendors, the authorities will consider the provision of 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 different insurers and that individuals who would like assistance understanding how the different insured products work together may contact the plan administrator for more information (and provide the contact information).

## Expressing FSA, HRA or HSA Reimbursements, and Wellness Program Rewards or Penalties in an SBC

If an employer offers reimbursement programs such as a health FSA, an HRA or health savings account (HSA) to enrollees in a medical plan, and permits the benefits under these accounts or programs to reduce cost sharing under the medical plan, the plan is permitted to combine information for all of these accounts and programs, and reflect them in a single SBC, as long as the SBC remains understandable. The same is true for wellness program credits or surcharges.

For example, the cost sharing implications of an HRA may be denoted in the SBC, where the SBC speaks to deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. Or the SBC may reflect potential adjustments in these amounts due to wellness program participation.

In these cases, the coverage examples in the SBC should note the assumptions used in creating them (the federal authorities' sample completed SBC includes an example of how to denote the effects of a diabetes wellness program).

## Multiple Coverage Tiers

Group plans typically offer an employee a choice, under each coverage option, between multiple coverage tiers (e.g., employee-only coverage, employee-plus-one coverage, employee-plus-family coverage, etc.).

Plans are not required to supply or make available to an individual a separate SBC for each coverage tier. Plans may combine information for different coverage tiers in one SBC, provided the appearance is understandable. The SBC's coverage examples should be completed using the cost-sharing features (e.g., deductible and out-of-pocket limits) for the employee-only coverage tier and the coverage examples should note this assumption.

## Multiple Deductible and Out-of-Pocket Expense Maximums

Some plans permit participants to select the deductible, copayment and co-insurance levels for a particular benefit option. In this case, the plan is not required to provide a separate SBC for every possible combination that a participant may select under that option. The plan may combine information for different cost-sharing selections (such as levels of deductibles, copayments, and co-insurance) in a single SBC, provided the SBC's appearance is understandable. This information may be presented in the form of options, such as deductible options and out-of-pocket maximum options. In these circumstances, the SBCs coverage examples should note the assumptions used in creating them. An example of how to note assumptions used in creating coverage examples is provided in the sample completed SBC prepared by federal authorities.

## Combining the SBC with the SPD, or Using a Cross-Reference to the SPD to Satisfy an SBC Requirement

SBCs may be provided either on a stand-alone basis or as part of the summary plan description (SPD) if certain requirements are met. If the SBC is provided as part of the SPD, all of the SBC's pages must remain intact and must be prominently displayed at the beginning of the materials (such as immediately after a table of contents).

Even though the SBC may be part of the SPD, the timing requirements for providing the SBC must be met. Note that there are other differences between the rules for providing SPDs and SBCs. These include the fact that SPDs are required to be furnished only to covered

participants, while the SBC must be furnished to participants and beneficiaries (i.e., dependents), although furnishing the SBC to the participant will normally be deemed to accomplish delivery to dependents.

Although an SBC may be combined in an SPD, it is not adequate to simply refer to the SPD as a way to satisfy a required SBC content element. For example, the SBC can't say, "See the deductible description in the SPD" in lieu of actually describing the deductible in the SBC. However, an SBC may include a reference to the SPD in the SBC footer. For example, a footer on the SBC could say, "Questions: Call 1-800-[insert] or visit us at www.[insert].com for more information, including a copy of your plan's summary plan description."

In addition, an SBC that includes all required SBC elements may include reference to specified pages or portions of the SPD in order to supplement or elaborate on that information.

> ***Recommendation:*** It's probably best to keep the SBC separate and apart from the Plan's SPD.

### Making Minor Adjustments to the SBC Format, such as Tinkering with Headers and Footers, Changing Row and Column Sizes, Carrying Over Information from One Page to Another, etc.

Although prohibited by the formal SBC template instructions, federal authorities (in a series of FAQs regarding SBCs) say they'll permit minor adjustments to an SBC's row or column size in order to accommodate the plan's information, as long as the information is understandable. The deletion of columns or rows is not permitted.

Rolling over information from one page to another is permitted. Also, a plan may include the model template's header on only the first page, and may include the footer on just the first and last pages of the SBC (the most recent model template doesn't contain much in the way of footers anyway).

## PART II: BUILDING AND REVIEWING AN SBC

Federal authorities re-issue from time to time updated model SBC templates, and updated, detailed instructions for completing them. Few employer/plan sponsors construct their own SBCs, relying instead on their health insurers or third-party administrators (TPAs) to supply compliant SBCs. Nevertheless, some plan sponsors desire to double-check the work of their insurers and TPAs, and the instructions are a good place to start, as they set forth detailed requirements (and options) for completing each cell in the model SBC template.

The templates, instructions, Uniform Glossary and other related documents are all available here:

https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Summary of Benefits and Coverage and Uniform Glossary

# APPENDIX A—SBC DELIVERY GRID

LOCKTON®

## APPENDIX A—SBC DELIVERY GRID

| Who | When | What | How | Notes |
|---|---|---|---|---|
| Current Enrollees (including COBRA enrollees) | At **open enrollment**: With open enrollment materials, if must *affirmatively* re-enroll or re-enrollment is evergreen but individual may select other options. | The SBC for the coverage option in which he or she is currently enrolled (presumably, the version of the SBC for the coming year). | Hard copy, or electronically if enrollment is electronic; if paper enrollment, may supply SBC electronically in accordance with stricter DOL rules. | Where the enrollee's current coverage option is being eliminated, we presume the plan may supply the new SBC for the option to which the enrollee's coverage is being mapped.<br><br>We presume the plan is to supply the new version of the SBC (i.e. for the coming year). If it is not available at open enrollment, the plan may supply the current year's version, but supply the new version prior to the first day of the new plan year.<br><br>Typically, SBCs delivered to the employee are deemed delivered to dependents unless the plan knows a dependent does not reside with the employee.<br><br>Plan may combine an SBC with other materials, such as the SPD or enrollment guide, if prominently displayed at the beginning of the document.<br><br>DOL's stricter rules for electronic disclosure require employee to have workstation access to network, or consent to e-delivery. |
| | NLT 30 days prior to **new plan year**, if re-enrollment is *automatic* and no opportunity to choose other option; may be later for insured plans where renewal is late (7 business days after renewal issued or committed to by insurer). | The SBC for the coverage option in which he or she is currently enrolled (presumably, the version of the SBC for the coming year). | Hard copy, or electronically if re-enrollment is electronic (presumably), otherwise in accordance with stricter DOL rules. | |
| | **Upon request**, SBC should be sent within 7 business days. | The requested SBC. | Hard copy, or electronically if the individual makes the request electronically. | |
| | NLT 60 days prior to any **mid-year material change** to coverage, that changes information reflected in the SBC. | Either an updated SBC, or a summary of the change (but consistent with style and format of SBC). | Hard copy, or electronically in accordance with stricter DOL rules. | |
| Special Enrollees | Within 90 days after **special enrollment**. | The SBC for the coverage option in which he or she enrolled. | Hard copy, or electronically in accordance with stricter DOL rules. | |

| Who | When | What | How | Notes |
|---|---|---|---|---|
| Individuals Eligible for Coverage Under a Particular Plan or Option but Not Yet Enrolled in that Plan or Option | Upon or prior to eligibility to enroll. | The SBC for each coverage option for which he or she is eligible. | Hard copy, or make available electronically in accordance with relaxed rules (see notes). | SBCs for individuals not yet enrolled may be provided electronically "such as by email or an Internet posting" as long as the SBCs are "readily accessible."<br><br>For SBCs posted on the Internet, this means the SBC must be in an accessible format (Word, PDF, HTML, etc.), and the plan must timely notify the individual via email or in writing (e.g., a postcard) about how to obtain the e-version, and that a paper version is available upon request.<br><br>Typically, SBCs delivered to the employee are deemed delivered to dependents unless the plan knows a dependent does not reside with the employee.<br><br>The plan may combine an SBC with other materials, such as the SPD or enrollment guide, if prominently displayed at the beginning of the document.<br><br>Apparently, there's no duty to affirmatively supply the SBC for the option in which the individual enrolls. |
| | At open enrollment: With or at time open enrollment materials are supplied. | The SBC for each coverage option for which he or she is eligible. | Hard copy, or make available electronically in accordance with relaxed rules (see notes). | |
| | Upon request, SBC should be sent within 7 business days. | The requested SBC. | Hard copy, or electronically in accordance with relaxed rules (see notes). | |

# APPENDIX B—DOL REQUIREMENTS FOR ELECTRONIC DELIVERY OF STANDARD ERISA NOTICES

## APPENDIX B—DOL REQUIREMENTS FOR ELECTRONIC DELIVERY OF STANDARD ERISA NOTICES

In this digital age many employers would prefer to provide ERISA-required notices to their employees in electronic format and via electronic means. Federal rules have not entirely kept pace with evolving technology in this regard. While rules for electronic availability and delivery of SBCs are a bit relaxed, the general rules regarding electronic delivery of ERISA-required notices remain a bit cumbersome.

For a description of those rules, click **here** or contact your Lockton Account Service Team.

# APPENDIX C—LIST OF COUNTIES

## APPENDIX C—LIST OF COUNTIES, AND MODEL NOTICE LANGUAGE

If Plan participants reside in a county that according the most recent census contains residents at least 10 percent of whom are fluent only in the same non-English language, the SBC provides a prominent notice of translation assistance (in that non-English language). Federal authorities update, from time to time, the list of counties; an example of a recent update is available **here**.

Below is the model language federal authorities say should be displayed "prominently" in an SBC, where the participant resides in a county relevant for purposes of this requirement. Federal authorities have offered this model language in four different languages.

SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].

CHINESE (**中文**): **如果需要中文的帮助**，请拨打这个号码 [insert telephone number].

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].

## Our Mission

To be the worldwide value and service leader in insurance brokerage, risk management, employee benefits, and retirement services

## Our Goal

To be the best place to do business and to work


RISK MANAGEMENT | EMPLOYEE BENEFITS | RETIREMENT SERVICES

lockton.com



(Ver. 07/27/15)
g:\lbg\2017\employer guide to the summary of benefits and coverage\employer guide to sbc\33623