NEWFRONT

Summary of Benefits and Coverage (SBC):

The Content and Distribution Rules for Employers

2025 Edition

Audio

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Guide Topics

The ACA Created an Additional Required Plan Summary Document for Employees

The SBC's Role Among Other Required Disclosures

- The ACA generally requires group health plans and health insurance issuers to provide SBCs to employees
- Designed as a short document describing the benefits and coverage offered under the plan in a uniform format
- Unlike the SPD, the SBC will look the same from plan option to plan option, employer to employer, and even when comparing vs. individual plans on the Exchange
- The SBC's brevity (cannot exceed four double-sided pages) and coverage examples for common situations also make the document quite useful for employees
- In short, the SBC has proven to fill an appropriate role in the employee-facing plan summary landscape by providing a relatively simple overview that allows for apples-to-apples comparison among multiple offerings

SBC for Employers Topics for Discussion:

1. **Required Content:** The SBC is subject to strict content, appearance, and formatting limitations to ensure uniformity
2. **When, What, How, Who?:** Because carriers and TPAs generally provide completed SBCs to the employer, these are the primary issues employers face in satisfying the SBC rules
3. **Mid-Year Changes:** Material modifications come with a 60-day advance notice requirement—a major shift from the SMM rules
4. **Languages:** SBCs must be provided in a "culturally and linguistically appropriate manner," with new DOL guidance updating the language requirements for 2025
5. **Enforcement:** The seemingly eternal good faith enforcement standard keeps chugging along, but for how much longer?

Which Plans are Subject to the SBC Rules?

General Rule:

Group Health Plans Must Provide SBC Unless Exception Applies

SBCs were a new requirement in the ACA first effective as of 2012. The SBC rules are applicable to:

- **Group & Individual Policies**
- **Small Group & Large Group Plan**
- **Self-Insured & Fully Insured Plans**
- **Grandfathered & Non-Grandfathered Plans**
- **ERISA & Non-ERISA Plans**

The SBC rules generally apply to all major medical plans.

Stated Purpose of the SBC:

The ACA generally requires all group health plans and health insurance carriers to provide an easy-to-read summary to help consumers compare the different features of health plans with an apples-to-apples comparison of costs, coverage, benefits, and other features that may be important to participants. The SBC must be in a short, uniform document that accurately describes the benefits and coverage under the plan.

Exception: Dental/Vision Plans Not Subject to SBCs

- Excepted Dental Benefits (almost all dental plans qualify)
  - Limited to treatment of the mouth, and under a separate policy or not integral to the group health plan
- Excepted Vision Benefits (almost all vision plans qualify)
  - Limited to treatment of the eye, and under a separate policy or not integral to the group health plan

Exception: Health FSAs Not Subject to SBCs

- Excepted Health FSAs (almost all health FSAs qualify)
  - Footprint Rule: All employees eligible for health FSA are also eligible for the major medical plan
  - $500 Rule: Employer nonelective contributions to the health FSA do not exceed $500 (more permitted if matching)

Other Plans Subject to SBCs?

- HSAs are not subject to the SBC rule because not a plan
- HRAs have no technical exception but limited guidance as to how to address—SBC format does not work well for an HRA
- Wellness programs that affect medical may be included in SBC

01

Content Requirements

Required SBC Content

Subject to Strict Appearance and Formatting Limitations, SBC Must Have:

Defined Terms

- Uniform definitions of standard insurance and medical terms (defined in the Uniform Glossary)

Coverage Description

- Description of the coverage (in at least 12-point font)
- Exceptions, reductions, and limitations of the coverage
- Cost-sharing amounts (deductible, copays, coinsurance)
- Continuation of coverage provisions (COBRA)
- Coverage examples (model has three, six permitted)

ACA Standards

- Statement as to whether the plan constitutes minimum essential coverage (i.e., satisfies individual mandate)
- Statement as to whether the plan provides minimum value (i.e., is at least as rich as a Bronze-level plan)

Summary Only

- Statement that the SBC is only a summary of the governing plan document

Contact/Access Information

- Contact information for questions
- An internet address for obtaining the certificate of coverage (if applicable)
- An internet address for obtaining a list of network providers (if applicable)
- An internet address for obtaining a list of formulary prescription drugs (if applicable)
- An internet address for obtaining the Uniform Glossary of Coverage and Medical Terms
  - DOL EBSA Summary of Benefits and Coverage and Uniform Glossary

How to Meet the SBC Content Requirements

Practical Reality

- Employers should almost never be in a position where they have to prepare the SBCs themselves

Fully Insured Plan:

- Insurance carrier almost always prepares the SBC

Self-Insured Plan:

- Usually prepared by the third-party administrator (TPA)—make sure TPA has agreed to perform this service on plan's behalf

1	**Start at the DOL EBSA SBC Main Page** • https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits
2	**Use the SBC Template for Plan Years Beginning On or After 1/1/21** • Available in Word and PDF formats, cannot exceed four double-sided pages
3	**Follow the Document "Instructions for Completing the SBC—Group Health Plan Coverage"** • Note: This document has *very* specific instructions to follow
4	**Use the "HHS Coverage Example Calculator and Related Information" to Prepare Coverage Examples** • Safe harbor approach until further guidance issued
5	**Use Terms in a Manner Consistent with the Uniform Glossary Definitions** • For example, "coinsurance" must refer to employee-share percentage of costs

SBCs Through the Years…

The SBC Content Continues to Evolve

The template SBCs have gone through two major sets of revisions since their introduction in 2012.

Initial Revisions
2017 Update

- Trimmed template from eight pages (four double-sided) to five pages (2 ½ double-sided)
- Added third coverage example for broken bone (simple fracture) treated with an emergency room visit
- Clearer description of whether plan constitutes “minimum essential coverage (i.e., satisfies indivdual mandate) and provided “minimum value” (i.e., at least as rich as Bronze-level plan)
- Removal of annual limits section (ACA prohibits lifetime and annual dollar limits on essential health benefits)
- Removal of Q&A page (incluidng references to pre-existing conditions, which are not longer permitted by the ACA)
- Updated Uniform Glossary of Health Coverage and Medical Terms with new definitions (from four pages to six pages)

Current Revisions
2021 Update

- Updates the “minimum essential coverage” disclosure to remove reference to tax penalty and instead focus on eligiblity for premium tax credit (TJCA reduced ACA indiivdual mandate tax penatly to zero)
- Removes definition of “individual responsibility requirement” from the Uniform Glossary to reflect TCJA
- Additional option for individual market policies to address “minimum value” disclosure (because concept not relevant for individual policies)
- Updates the coverage example calculator, guides, and narratives with improved treatment protocols and better logic to align with underlying assumptions for most plans’ cost-sharing structure
- *New for 2025: Updated foreign language standards (slides 21-23)*

The Sample Completed SBC Template

SBC Page Limit Fun Fact #1:

- ACA requires that the SBC "not exceed four pages in length"

Where to Access:

DOL EBSA
Summary of Benefits and Uniform Glossary

https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2022-12/31/2022
Coverage for: Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 / individual or $1,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage and $300 for occupational therapy services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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The Sample Completed SBC Template

SBC Page Limit Fun Fact #2:

- 2012 SBC regulations interpret ACA to provide “that the four-page limitation is four double-sided pages”

Where to Access:

DOL EBSA
Summary of Benefits and Uniform Glossary

https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/office visit and 20% coinsurance for other outpatient services; deductible does not apply	40% coinsurance	None
	Specialist visit	$50 copay/visit	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$50 copay/test	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs (Tier 1)	$10 copay/prescription (retail & mail order)	40% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail & mail order)	40% coinsurance	
	Non-preferred brand drugs (Tier 3)	40% coinsurance	60% coinsurance	
	Specialty drugs (Tier 4)	50% coinsurance	70% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100/day copay	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance for anesthesia.

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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The Sample Completed SBC Template

SBC Page Limit Fun Fact #3:

- 2015 SBC regulations "retain the interpretation set forth in the 2012 final regulations that the SBC can be four double-sided pages"

Where to Access:

DOL EBSA
Summary of Benefits and Uniform Glossary

https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$30 copay/visit	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/office visit and 20% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60 visits/year
	Rehabilitation services	20% coinsurance	40% coinsurance	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	60 visits/calendar year
	Durable medical equipment	20% coinsurance	40% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	$35 copay/visit	Not covered	Coverage limited to one exam/year.
	Children's glasses	20% coinsurance	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	No charge	Not covered	None

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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The Sample Completed SBC Template

SBC Page Limit Fun Fact #4:

- The current SBC template for use starting in 2021 was trimmed from eight pages (four double-sided) to five pages (2 ½ double-sided)

Where to Access:

DOL EBSA
Summary of Benefits and Uniform Glossary

https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[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].]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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The Sample Completed SBC Template

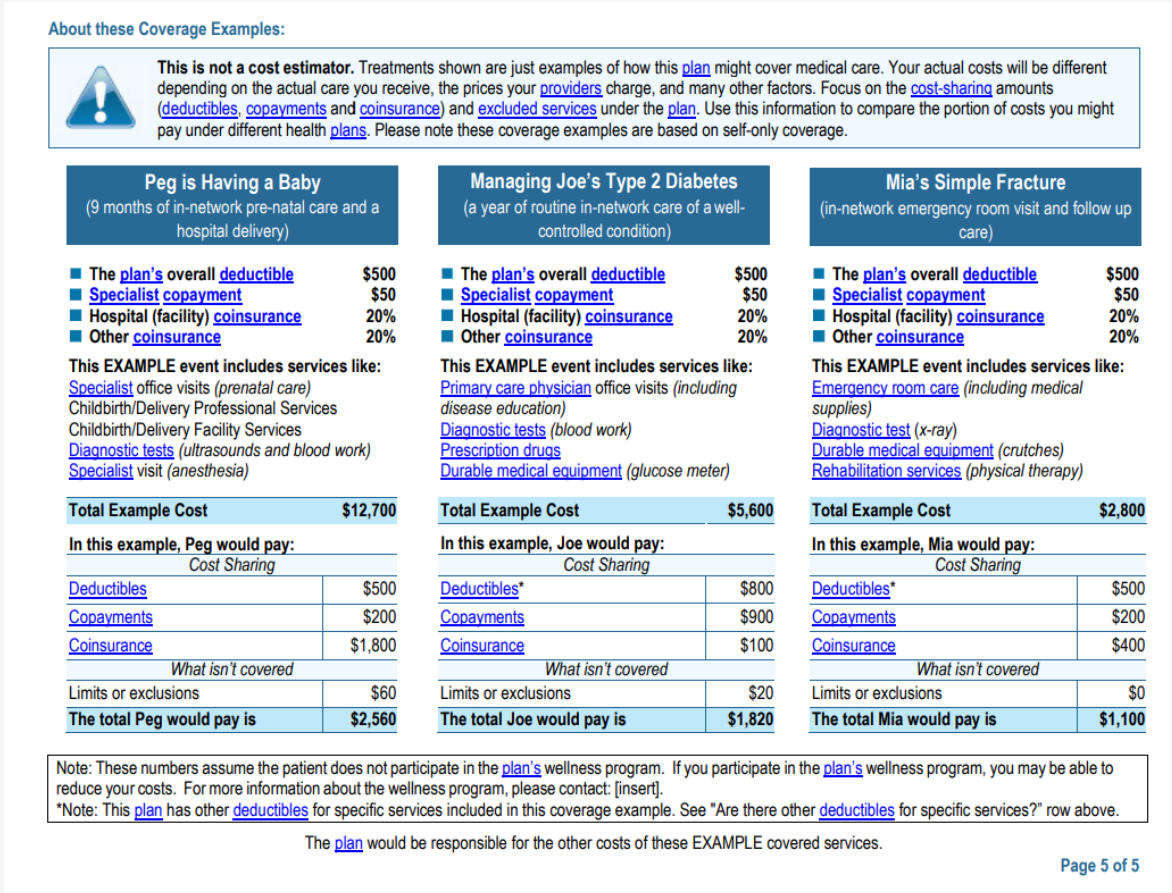
SBC Page Limit Fun Fact #5:

- SBCs are almost always provided electronically, where there's no such thing as double-sided pages—but the Departments still view them as double-sided!

Where to Access:

DOL EBSA
Summary of Benefits and Uniform Glossary

https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits



About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%
This EXAMPLE event includes services like:	
Specialist office visits *(prenatal care)*	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests *(ultrasounds and blood work)*	
Specialist visit *(anesthesia)*	
Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%
This EXAMPLE event includes services like:	
Primary care physician office visits *(including disease education)*	
Diagnostic tests *(blood work)*	
Prescription drugs	
Durable medical equipment *(glucose meter)*	
Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$800
Copayments	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%
This EXAMPLE event includes services like:	
Emergency room care *(including medical supplies)*	
Diagnostic test *(x-ray)*	
Durable medical equipment *(crutches)*	
Rehabilitation services *(physical therapy)*	
Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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02

When, What, How, Who?

When to Provide the SBC

Event	Timeframe

Upon Application
• Initial Enrollment (New Hires)
• Newly Eligible Employees
	Provide as Part of Any Written Application Materials Distributed for Enrollment
	• If no written applications materials for enrollment, provide no later than the first date the participant is eligible
	  • If SBC information changes during period between application and first day of coverage, provide updated SBC no later than the first day of coverage
	  • No requirement to provide the SBC if employer has already provided it upon request and there has been no change since previously provided

Special Enrollment • Loss of Other Coverage • Birth, Adoption, Marriage • Medicaid/CHIP Events	**Provide Within 90 Days from Enrollment Upon Employee Experiencing HIPAA Special Enrollment Event** • Same 90-day timeframe required as for SPD distribution when employees are first covered under the plan
Open Enrollment	**Provide No Later Than the Date Employer Distributes Written Open Enrollment Materials** • If the plan has rolling elections (i.e., passive enrollment), deadline to provide is instead no later than 30 days prior to the first day of the new plan year • For fully insured plans where the policy is not finalized before the 30-day period, exception provides that employers must provide no later than seven business days after policy issuance or receipt of written confirmation (does not apply for self-insured plans)
Upon Request	**Provide as Soon as Practicable, Not to Exceed Seven Business Days Following Receipt of the Request**

What SBCs to Provide

Event	What to Provide
Upon Application • Initial Enrollment (New Hires) • Newly Eligible Employees	**Provide the SBC for Each Benefit Package (Plan Option) for Which the Employee is Eligible** • SBCs for all the options offered under the plan in which the employee could choose to enroll
Special Enrollment • Loss of Other Coverage • Birth, Adoption, Marriage • Medicaid/CHIP Events	**Provide the SBC for Each Benefit Package (Plan Option) for Which the Employee is Eligible** • SBCs for all the options offered under the plan in which the employee could choose to enroll
Open Enrollment	***Currently Enrolled Employees*** **Only Required to Provide the SBC for the Benefit Package In Which Employee is Currently Enrolled** • SBCs for other benefit packages must be available upon request (as soon as practicable, within seven days) ***Not Currently Enrolled Employees*** **Provide the SBC for Each Benefit Package (Plan Option) for Which the Employee is Eligible** • SBCs for all the options offered under the plan in which the employee could choose to enroll
Upon Request	**Provide the SBC for Each Benefit Package (Plan Option) for Which the Employee is Eligible**

SBC Electronic Disclosure Rules

The SBCs add additional electronic disclosure safe harbors.

Employees still always have the right to request a paper copy free of charge.

Special Relaxed SBC Rule: Online Enrollment

- SBCs may be distributed electronically **in connection with online enrollment** to any employee
- Applies for employees enrolling online (initial enrollment or open enrollment) where SBCs are made available as part of the employees' online enrollment process

Special Relaxed SBC Rule: Online Request

- SBCs may be distributed electronically in response to an online employee request for the SBC

Special Relaxed SBC Rule: Eligible But Not Enrolled

SBC may be distributed electronically if:

1. The format is readily accessible; **and**
2. If provided on the internet, employer must notify the employee in paper form (e.g., a postcard) or by email that the documents are available on the internet, including the internet address, plus include a notice that the documents are available in paper form upon request

Other Situations: Standard ERISA Safe Harbor

Employees with Work-Related Computer Access Integral to Their Job Duties

- **No employee consent required**—these employees can receive electronic distribution of ERISA materials (e.g., SPD, SMM) by default (i.e., opt-out)

Employees without Work-Related Computer Access Integral to Their Job Duties

- Employee must electronically **affirmatively consent** to electronic disclosure (i.e., opt-in)
  - Form of affirmative consent must reasonably demonstrate the individual's ability to access information in the electronic form that will be used (e.g., the internet)

Who Must Receive SBCs

Unlike the standard ERISA SPD/SMM rules, both employees and dependents have the right to receive SBCs—but a major carve out applies.

Standard ERISA Rule

Applies to SPD and SMM Distribution

- Only required to provide to employees (not dependents) for health and welfare plans
- Includes COBRA participants
- No requirement to provide to dependents (spouse, domestic partner, children, etc.) even if also covered under the plan

Special SBC Rule

Employees and Dependents Included

- Employers must provide the SBC to both employees and dependents (spouse, domestic partner, children, etc.)
- Includes COBRA participants
- Different from the SPD/SMM rules where the DOL rules specifically exclude dependents from required distribution

Major Carve Out

Employee and Dependent Live at Same Address

- No requirement to separately provide SBCs to dependents if the dependent's last known address is the same as the employee
- If a dependent's last known address is different from the employee's, employer must provide separate SBC to the dependent at the dependent's last known address

Who Must Provide SBCs

For fully insured plans, both the group health plan (generally the employer as plan administrator) and the insurance carrier are responsible and directly liable for providing the SBCs—no such rule applies directly to the TPA for self-insured plans.

Who is Responsible for Providing SBCs
Fully Insured vs. Self-Insured

Fully Insured Plans

- Both the plan (employer) and the insurance carrier are legally responsible for providing SBCs
  - *Anti-Duplication Exception:* No requirement for employer to provide SBC if insurance carrier has already provided (employer may still be liable for failures if conditions in righthand column not satisfied)

Self-Insured Plans

- No insurance carrier, so only the plan (employer) is directly responsible (not TPA)
  - *Contractual Delegation:* Can contract with TPA to handle SBC obligations (see righthand column)

Contractual Shifting of Liability
Applies for Both Insurance Carrier or TPA

The employer is considered to have satisfied its requirement to provide the SBC if it contracts with the TPA/carrier to provide the SBCs **and meets the following three conditions:**

1. **Monitoring Performance:** The employer **monitors performance** under the contract;
2. **Correcting Failures:** If the employer has knowledge that the TPA/carrier is not properly providing the SBCs, and the employer **has all information necessary** to correct the failure, the employer must correct the failures as soon as practicable
3. **Addressing Uncorrectable Failures:** If the employer has knowledge that the TPA/carrier is not properly providing the SBCs, and the employer **does not have all of the information necessary** to correct the failure, the employer must communicate with the affected participants regarding the failures, and begin taking steps as soon as possible to avoid future violations

03

Mid-Year Changes

Mid-Year SBC Material Modifications

Applies only to a modification **“that occurs other than in connection with renewal or reissuance of coverage”** (i.e., does not apply for new plan year changes).

- Mid-year SBC changes are treated differently from the rules to which employers have become accustomed for SMMs
- **60-DAY ADVANCE NOTICE REQUIREMENT FOR SBCs**
- Applies to any mid-year material modification that affects the content of the SBC—even enhancements!
- Requires distribution of an updated SBC reflecting the material modifications or a separate notice describing only the material modifications

SBC Material Modifications

60-Days Advance Notice

- Updated SBC must be provided **60 days prior** to the date on which the modification will become effective
- Separate notice just describing modifications is also permitted
- Applies to any material modification affecting SBC content

“Material” Modification Defined

- Any modification that would be considered by an average participant to be an important change in covered benefits or other terms of coverage under the plan

SMM Material Modifications

60+ Days After Adoption

General Rule: 210 Days

- SMM must be provided within **210 days after** the close of the plan year in which the modification was adopted

Material Reduction in Health Benefits: 60 Days

- SMM must be provided within **60 days after** the date of adoption of material reduction of covered services or benefits for a group health plan (best practice still to provide in advance if possible)

04

Required Languages

Required SBC Lanugage Translations

SBCs Must be Provided In a **“Culturally and Linguistically Appropriate Manner”**

The SBC Language Requirements

- Employers must satisfy the following standards for the SBC:
  - Oral language services (e.g., phone customer service hotline) that includes answering questions in the non-English language
  - Upon request, the plan must provide the SBC translated in the non-English language
  - Must include a prominently displayed statement in SBC in the non-English language of how to access these language services
- SBC template includes access taglines in non-English languages on page four of the SBC (“Language Access Services”)

When the SBC Language Services Requirement Applies

- **SBC language services required (including translations upon request) where provided to an employee/dependent in county where at least 10% of the the population residing in the county is literate only in the same non-English language**
  - Departments use survey and census information to periodically update which counties qualify
  - Most recent Culturally and Linguistically Appropriate Services County Data (CLAS County Data) is from 2023

New 2023 CLAS County Data Applies Going Forward

- **Applies to SBCs for Plan Years beginning on or after January 1, 2025**

Where to Access 2023 CLAS County Data: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/clas-county-data-2023.pdf

Where to Access SBC Translations: https://www.cms.gov/marketplace/resources/forms-reports-other

Required SBC Lanugage Translations

SBCs Must be Provided In a **“Culturally and Linguistically Appropriate Manner”**

Which Languages Qualify? (*New for 2025)

- **Spanish**
  - 216 Counties in AZ, AK, CA, CO, FL, GA, ID, IA, KS, MN, NE, NM, NY, NC, OK, OR, PR, TX, VA, WA
- **Tagalog (includes Filipino)**
  - 10 Counties in AK, Northern Mariana Islands
- **Samoan***
  - 3 Counties in American Samoa
- **Chamorro***
  - 3 Counties in Northern Mariana Islands
- **Pennsylvania Dutch (Includes Yiddish/West Germanic)***
  - 2 Counties in IN, OH
- **Chinese (includes Mandarin and Cantonese)**
  - 1 County in CA
- **Navajo**
  - 1 County in AZ
  - *Note:* Navajo oral translation also available (mp3 format)
- **Carolinian***
  - 1 County in Northern Mariana Islands

New 2023 CLAS County Data Applies Going Forward

- **Applies to SBCs for Plan Years beginning on or after January 1, 2025**

Where to Access 2023 CLAS County Data: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/clas-county-data-2023.pdf

Where to Access SBC Translations: https://www.cms.gov/marketplace/resources/forms-reports-other

05

Enforcement

Will SBC Enforcement Finally Ramp Up?

The Neverending Story: Good Faith Enforcement Safe Harbor

SBC Penalty Provisions

- An employer that willfully fails to provide SBCs in accordance with the SBC rules is subject to a penalty of up to $1,406 (indexed) per failure
  - Failure with respect to each employee or dependent constitutes a separate offense
  - If the employee has a family of four, the penalty could be up to $5,624!
- Failures may also trigger the standard $100/day ACA excise tax liability under IRC §4980D
- Failures may also be considered a breach of fiduciary duty under ERISA

Temporary Good Faith Standard Appears to Still Apply

- Since SBCs took effect in 2012, Tri-Agencies (DOL/IRS/HHS) have stated that they "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 [SBC rules]"
- Tri-Agencies reiterated in 2014 that this good faith enforcement safe harbor from potential penalties applies "until further guidance is provided"
- Although it raised eyebrows that the good faith standard went unaddressed in the most recent 2015 SBC regulations, no further guidance has wound down this long-lasting safe harbor

Will the IRS Finally Enforce the SBC Rules?

- During the Obama Administration when the good faith standard began, SBCs were new and therefore it made sense to have a transitional period
- Given the long runway now (over a decade) for employers to adjust, it seems appropriate to consider an end to the penalty relief soon
- As we enter a new era of SBC templates/translations, it may be time to wind down the relief and begin enforcement

WRAP-UP

Takeaways

SBCs for Employers – Top Five Issues

Remember: SBC Templates, the Uniform Glossary, Instructions, Coverage Example Calculators, Translations, and More Available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits

1 Required Content

- The SBC rules set forth very specific content, formatting, and appearance requirements
- The document cannot exceed four pages, but the Departments have interpreted that limitation to mean double-sided pages

Practical Reality:

- Everyone uses the cookie cutter templates from the Departments
- Where fully insured, the carrier almost always pepares the SBC
- For self-insured, the TPA generally will also agree to prepare the SBCs

2 When, What, How, Who?

- Provide SBCs upon initial enrollment, special enrollment, open enrollment, and upon request within set timeframes
- Provide the SBC for each plan option for which the employee is eligible in most cases—but at open enrollment only requirement is to provide current plan option SBC to enrolled EEs
- Relaxed electronic distribution rules allow employers to provide SBCs electronically in large majority of situations, especially if they have **online enrollment**
- SBCs go to employees and dependents—but one is sufficient if the dependent lives with the employee

3 Mid-Year Changes

- SBCs mid-year changes are different from the standard SMM rules!
- 60-day **advance notice** requirement for SBC mid-year material modifications
- Applies to any mid-year material modification of SBC content—even enhancements of coverage
- Can be handled through separate notice addressing changes or updated SBC
- SMM rule for non-SBC situations provides until 60 days after adoption of material reductions to health benefits, or 210 days after the plan year for other changes

4 Required Languages

- ACA requires that SBC be provided in a “culturally and linguistically appropriate manner’
- Requires oral language services (phone hotline), translated SBCs, and statement in SBC of how to access language services
- Applies if **at least 10% of the population** residing in the county is literate only in the same non-English language
- New survey and census data applies for 2025 SBCs for where language services are needed

SBC Language Requirements:

- Spanish, Tagalog, Samoan, Chamorro, Pennsylvania Dutch, Chinese, Navajo, Carolinian

5 Enforcement

- We’ve been in a good faith enforcement safe harbor since the SBC requirement first began in 2012
- When will it end?
  - There does not appear to be a strong justification for continuing the good faith enforcement standard all these years later
  - **Reasonable to predict that the IRS will turn to standard enforcement soon**
- When standard enforcement applies, there are significant potential penalties for SBC failures
  - **Up to $1,406 penalty applies for willful SBC failures**
  - Failure with respect to each employee and dependent constitutes a separate offense!

Content Disclaimer

Summary of Benefits and Coverage (SBC)

The intent of this analysis is to provide the recipient with general information regarding the status of, and/or potential concerns related to, the recipient's current employee benefits issues. This analysis does not necessarily fully address the recipient's specific issue, and it should not be construed as, nor is it intended to provide, legal advice. Furthermore, this message does not establish an attorney-client relationship. Questions regarding specific issues should be addressed to the person(s) who provide legal advice to the recipient regarding employee benefits issues (e.g., the recipient's general counsel or an attorney hired by the recipient who specializes in employee benefits law).

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Thank you

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