UBA
ACA Advisor

What you need to know
about the Affordable Care Act

Summary of Benefits and Coverage (SBC) Frequently Asked Questions

Updated January 2020

General Information

Q1. What is a Summary of Benefits and Coverage?

A1. A Summary of Benefits and Coverage (SBC) is a four-page (double-sided) communication required by the federal government. It must contain specific information, in a specific order and with a minimum size type, about a group health benefit's coverage and limitations.

Q2. Who must provide an SBC?

A2. For fully insured plans, the insurer is responsible for providing the SBC to the plan administrator (usually this is the employer). The plan administrator and the insurer are both responsible for providing the SBC to participants, although only one of them actually has to do this.

For self-funded plans, the plan administrator is responsible for providing the SBC to participants. Assistance may be available from the plan administrator's TPA, advisor, etc., but the plan administrator is ultimately responsible. (The plan administrator is generally the employer, not the claims administrator.)

Q3. When is an SBC required?

A3. An SBC is required whenever application or open enrollment materials are provided to new hires or current employees. If no application or open enrollment materials are given, an SBC must be provided when the person can first enroll.

Q4. Are any plans exempt from this requirement?

A4. No. This requirement applies to all employers – private, government, and not-for-profit, fully insured and self-funded, grandfathered and non-grandfathered. There is no minimum employer size to have this obligation.

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However, there is a delayed effective date of September 23, 2014, for closed blocks of insured business. If a plan or issuer meets the following conditions, the Department of Labor (DOL) will not take any enforcement action against the plan or issuer for failing to provide the SBC before September 23, 2014:

- The insured product is no longer being actively marketed;
- The health insurer stopped actively marketing the product prior to September 23, 2012; and
- The health insurer has never provided an SBC with respect to the insured product.

In addition, expatriate plans did not have to provide SBCs until the 2016 plan year. (An expatriate plan is one designed to cover employees who are living overseas.)

Q5. What types of plans must provide SBCs?

A5. All group health plans must provide SBCs unless they are specifically exempted. Exempted plans include:

- Standalone dental and vision
- Health FSAs unless the plan is not an "excepted benefit" (see Q&A 16 for details)
- Health savings accounts (HSAs), although the high-deductible health plan will need an SBC; the HSA can be mentioned as a source of funds to meet deductibles, coinsurance, etc., if desired
- Retiree only plans
- Medicare supplement (Medicare Advantage)
- Hospital indemnity and specified diseases
- Long-term care
- Accident and disability

Q6. Are SBCs needed for wellness programs, EAPs and HRAs?

A6. In certain circumstances, yes. See Q&As 12 - 14.

Completing the SBC

Q7. What information must be included in an SBC?

A7. An SBC must contain:

- Uniform definitions of standard insurance terms and medical terms (provided in the glossary)
- A description of the coverage for certain categories of benefits
- The exceptions, reductions, and limitations of the coverage
- The cost-sharing provisions of the coverage (deductible, coinsurance, and copayment obligations)
- A statement as to whether the plan offers minimum essential and minimum value coverage
- The renewability and continuation of coverage provisions
- Coverage examples

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- A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage
- Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance)
- For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers
- Disclosure of tiered networks
- A statement that warns participants that they could receive out-of-network providers while they are in an in-network facility
- A statement that a consumer could receive a "balance bill" from an out-of-network provider
- For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage
- The column for "Limitations, Exceptions, & Other Important Information" must contain core limitations, which include:
  - When a service category or a substantial portion of a service category is excluded from coverage (that is, the column should indicate "brand name drugs excluded" in health benefit plans that only cover generic drugs);
  - When cost sharing for covered in-network services does not count toward the out-of-pocket limit;
  - Limits on the number of visits or on specific dollar amounts payable under the health benefit plan; and
  - When prior authorization is required for services.
- An Internet address for obtaining the uniform glossary, a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available
- Qualified health plan issuers must disclose whether abortion services are covered or excluded, and whether coverage is limited to excepted abortion services, for plans sold through an individual market Exchange.

Important: The agencies have issued **very specific** instructions on how to complete the SBC. If you are completing an SBC, you need to read and follow the instructions. The instructions are available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Group-Instructions-4-4-clean-MM-508.pdf. For plans beginning on or after January 1, 2021, the instructions are available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Group-Instructions-11-2019.pdf.

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Since these instructions were issued, the DOL has made a few liberalizations. They are:

- If a plan's terms deviate significantly from the template or instructions, you may modify the template/entries to the extent needed to be accurate.
- You only need to include the footer on the first and last page and the header only needs to be on the first page.
- When completing the header, either the company name, any insurer name or the plan name can be listed first.
- If there are multiple plan options, list the name commonly used; if there is no common name, a generic name is fine.
- The requirement to provide an Internet address to obtain an actual individual underlying policy or group certificate does not apply to self-insured plans. Related obligations of availability of the documents under ERISA and the DOL claims procedures still apply to self-insured plans. The government "encourages issuers" to make all relevant policy documents easily accessible.

A blank SBC for plan years beginning on or after April 1, 2017, is at https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-template-final.pdf. A blank SBC for plan years beginning on or after January 1, 2021, is at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SBC-Template-Accessible-Format-11-2019.pdf.

A sample completed SBC for plan years beginning on or after April 1, 2017, is at https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-completed-final.pdf. A sample completed SBC for plan years beginning on or after January 1, 2021, is at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Sample-Completed-SBC-Accessible-Format-11-2019.pdf.

Q8. What changes have been made to the SBC for 2017 through 2021?

A8. On April 6, 2016, the Centers for Medicare and Medicaid Services (CMS), the DOL, and the Department of the Treasury issued the final 2017 summary of benefits and coverage (SBC) template, group and individual market SBC instructions, uniform glossary of coverage and medical terms, a coverage example calculator, and calculator instructions. The SBC must be used for plan years with open enrollment periods beginning on or after April 1, 2017. In November 2019, CMS, the DOL, and the Treasury issued the final 2021 SBC template, group and individual market SBC instructions, uniform glossary of coverage and medical terms, a coverage example calculator, and calculator instructions. The SBC must be used for plan years with open enrollment periods beginning on or after January 1, 2021.

Impact of ACA Section 1557 – Addendum Required for Covered Entities

On May 13, 2016, the Department of Health and Human Services (HHS) issued a final rule implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA) that took effect on July 18, 2016. Under these regulations, covered entities must provide notices stating they do not

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discriminate on certain grounds in "significant public-facing publications." HHS confirmed that an SBC is a significant public-facing publication.

ACA Section 1557 provides that individuals shall not be excluded from participation, denied the benefits of, or be subjected to discrimination under any health program or activity which receives federal financial assistance from HHS, on the basis of race, color, national origin, sex, age, or disability. The rule applies to any program administered by HHS or any health program or activity administered by an entity established under Title I of the ACA. These applicable entities are "covered entities" and include a broad array of providers, employers, and facilities. State-based Marketplaces are also covered entities, as are Federally-Facilitated Marketplaces.

The final regulations are aimed primarily at preventing discrimination by health care providers and insurers, as well as employee benefits programs of an employer that is principally or primarily engaged in providing or administering health services or health insurance coverage, or employers who receive federal financial assistance to fund their employee health benefit program or health services. Employee benefits programs include fully insured and self-funded plans, employer-provided or sponsored wellness programs, employer-provided health clinics, and longer-term care coverage provided or administered by an employer, group health plan, third party administrator, or health insurer.

Practically speaking, employers with fully insured group health plans will be subject to the regulations (because the carrier is a covered entity and is prohibited from selling discriminatory plans), and many self-funded employers will be considered a covered entity based on their business model or financial details. Furthermore, most third party administrators (TPAs) will be considered a covered entity. The Office of Civil Rights (OCR) will investigate a TPA when there is alleged discrimination in the administration of the plan. However, if the alleged discrimination is in benefit plan design (that is, the choice of the employer), the OCR will process the complaint against the employer or plan sponsor. If the OCR lacks jurisdiction over the employer, it will refer the matter to the Equal Employment Opportunity Commission (EEOC). This means that employers who are not covered entities, but have a self-funded group health plan that utilizes a TPA that is a covered entity, could become the subject of an EEOC investigation for discriminatory business practices.

Employers with self-funded group health plans should seek legal counsel to determine if they are a covered entity, and to obtain legal advice on the applicability of these regulations to their individual situation.

Covered entities must take steps to notify beneficiaries, enrollees, applicants, or members of the public of their nondiscrimination obligations with respect to their health programs and activities. Covered entities are required to post notices stating that they do not discriminate on the grounds prohibited by Section 1557, and that they will provide free (and timely) aids and services to individuals with limited English proficiency and disabilities. These notices must be posted in conspicuous physical locations where the entity interacts with the public, in its significant public-facing publications, and on its website home page. In addition, covered entities that employ 15 or more persons must designate a responsible employee to coordinate the entity's compliance with the rule and adopt a grievance procedure. Employers who are covered entities should seek advice of counsel on the ways these requirements apply to them and their group health plan, and

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employers who are not covered entities but have a fully insured group health plan should discuss how the insurance carrier will meet these requirements.

The OCR has provided a model notice and model statement of nondiscrimination, and taglines for employers to use. The OCR has also created an FAQ and table relating to the top 15 languages spoken in each state.

HHS has stated that an SBC is a publication that is “significant” under the Section 1557 regulations. As a result, CMS requires the use of an addendum to the SBC to accommodate applicable language access standards. Accordingly, covered entities required to provide a SBC must include the nondiscrimination notice and taglines in its addendum along with other applicable language access standards. This addendum must contain only the Section 1557 nondiscrimination notice and taglines and other applicable language access information.

Q9. Do I need a separate SBC for each benefit option?

A9. You do not need a separate SBC for each benefit option as long as you can illustrate multiple options clearly. So, for example, you can show multiple coverage tiers and deductible/coinsurance/copay options on one SBC if the balance of the coverage is very similar. If you prefer to create a separate SBC for each tier, PPO option, etc., that is fine, too.

Q10. How do I handle dental benefits?

A10. Stand-alone dental benefits (those that are elected separately from medical) do not need an SBC. You would list “Dental Care (Adult)” as a “Service Your Plan Does Not Cover” since it is not covered under the medical plan that the SBC is describing.

Integrated dental benefits (those that are elected as part of medical) would be listed as “Dental Care (Adult)” under “Other Covered Services,” with no additional detail given.

Q11. How do I handle vision benefits?

A11. Stand-alone vision benefits (those that are elected separately from medical) do not need an SBC. You would list “Routine eye care (Adult)” as a “Service Your Plan Does Not Cover” since it is not covered under the medical plan that the SBC is describing.

Integrated vision benefits (those that are elected as part of medical) would be listed as “Routine eye care (Adult)” under “Other Covered Services,” with no additional detail given.

Q12. How do I handle an HRA?

A12. Beginning in 2014, most health reimbursement arrangements (HRAs) needed to be integrated with a medical plan. (There are exceptions to the integration rule for Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs) as of January 1, 2017, and for individual coverage health reimbursement arrangements (ICHRAs) starting on January 1, 2020.) If the HRA is integrated with the medical plan, you may include the amount of the employer contributions to the HRA to the extent they are available to reduce deductibles, etc. and explain the HRA contribution is available for cost sharing.

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A standalone HRA will need an SBC. The employer should complete the SBC to reflect the HRA's coverage (which means that many sections will be completed as "not applicable").

Q13. How do I handle an EAP?

A13. If the employee assistance program (EAP) is a group health plan, it will need an SBC. It may be possible to note those services on the medical SBC (see the sample Coverage Example for diabetes in the SBC instructions for a possible approach); if the services are not part of the health plan or are very complex, the employer should complete the SBC to reflect the EAP's coverage (which means that many sections will be completed as "not applicable").

Note: Because of the variety of services provided by EAPs, it is not possible to say whether all EAPs are or are not "group health plans." In general, the more medical care that is provided by the EAP, the more likely it is that the EAP is a group health plan. So, for example, an EAP that only provides education or referrals would not be a group health plan. An EAP that provides significant direct counseling probably is a group health plan.

Q14. How do I handle a wellness program?

A14. A wellness program that is a group health plan will need to provide an SBC. If the wellness program is a part of the health plan you may include a brief description of those services and/or incentives on the medical SBC. See the sample Coverage Example for diabetes in the SBC instructions for a possible approach if completion of the program reduces the deductible, coinsurance or copays. If a wellness program simply affects the health plan premium, it will not affect the medical plan SBC (unless the SBC includes the premium) and a separate SBC is not needed.

Note: Because of the variety of approaches taken by wellness programs, it is not possible to say whether all wellness programs are or are not "group health plans." In general, the more medical services the program provides, the greater the chance it is a group health plan. Whether a health goal is involved also matters. So, for example, if the reward for completing a health risk assessment is a gift card, and no action is taken based on the person's HRA results, the program is not a group health plan and no SBC is needed. If the wellness program provides medical care (for example, special services for diabetics), it is likely that the wellness program is a group health plan.

Q15. How do I handle an HSA?

A15. Health savings accounts (HSAs) are not considered "group health plans" and do not need an SBC (although the underlying high deductible health plan will need one). Employers may include the amount of any employer contribution to an HSA to the extent they are available to reduce deductibles, etc. and explain the HSA contribution is available for cost sharing.

Q16. How do I handle an FSA?

A16. An SBC is not needed for a flexible spending account (FSA) if the health FSA is an "excepted benefit." To be an "excepted benefit" the employee must also be eligible for group medical coverage through the employer, and the health FSA must limit the maximum payable to two times the participant's salary reduction or, if greater, the participant's salary reduction plus $500. Practically speaking, health FSAs can include employer contributions of $500 or up to a dollar-for-

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dollar match of each participant's election. If an employer makes any health FSA contributions, it may include the amount of any employer contribution to the health FSA to the extent they are available to reduce deductibles, etc., and explain the FSA contribution is available for cost sharing.

Q17. How do I handle carve-out benefits (such as prescription drug or behavioral health)?

A17. Until further guidance is issued, fully insured plans have several options:

- They can arrange with one insurer to include the information from the other insurer.
- They can combine the two into a single SBC themselves.
- They can provide each SBC, with a note advising participants that coverage is provided by more than one carrier, the SBCs should be read together, and the plan administrator can be contacted for help with understanding how the coverages work together; plan administrator contact information must be provided.

Self-funded plans will need to do their best to combine the multiple coverages into a single SBC.

Q18. Do I need to include information on premiums/contributions?

A18. Premium and contribution information is not required.

Q19. Can I include information on premiums/contributions?

A19. Yes, but it must be provided at the end of the SBC.

Q20. If the plan is grandfathered, do I need to state this?

A20. No, this disclosure is not needed on the SBC. If you wish to include a statement that the plan is grandfathered you can, but it must be at the end of the SBC.

Q21. Can I simply reference the SPD in the SBC?

A21. You cannot substitute a reference to the summary plan description (SPD) for any required information. You can create a footnote advising the reader to consult the SPD or certificate for more information, including a reference to particular page numbers for more information about a specific item.

Q22. Can I change the format or order of the SBC?

A22. Generally, no. You can widen columns.

Q23. Can I reword the "Why It Matters" responses?

A23. No.

Q24. Must the SBC be in color?

A24. No, it can be in color or grayscale.

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Q25. Why is this so inflexible?

A25. The purpose of the SBC is to make it easier for employees to compare coverage options. The regulatory agencies believe that consistent presentation will make it easier for employees to do side-by-side comparisons.

Q26. How often do I need to update the SBC?

A26. You only need to update the SBC at renewal/open enrollment unless you make a material change during the year. In that case, at least 60 days **before** the effective date of the change, you must either distribute an updated SBC or provide written notice of the change. Distributing the revised SBC or notice will qualify as a summary of material modifications (SMM) for ERISA purposes.

Q27. What is a material change?

A27. A material change is something addressed in the SBC that the average participant would consider important, like a change in deductible, coverage for a new benefit or a whole new network. It can be an increase in benefits or a reduction. Regulatory changes normally will not be considered a material change that would require a mid-year notice or reissuance of the SBC.

Completing the Coverage Examples

Q28. How do I prepare the coverage examples?

A28. The coverage examples are based on information provided by the regulatory agencies regarding the projected dates of service and the anticipated cost of certain prescribed services (maternity, care of diabetes, and simple fracture). The plan's actual cost sharing (deductible, co-pays and coinsurance) and any applicable exclusions or limits should be used to illustrate the "Patient pays" entries.

Q29. If I illustrate several benefit options in one SBC, what do I base the comparison on?

A29. You should illustrate self-only coverage and clearly state on the SBC that self-only coverage is being illustrated.

Q30. Has the government provided any assistance with these calculations?

A30. HHS/CMS has posted a calculator that can be used by employers to complete the comparison. Employers are **not** required to use this calculator.

The calculator and instructions are available at Other Resources - Centers for Medicare & Medicaid Services (scroll down to Summary of Benefits and Uniform Coverage).

Q31. The costs we are supposed to use in the examples are much more (or less) than we typically see. Can or should I use my plan's data?

A31. No. **Employers must use the HHS-supplied costs, even though they may not reflect their plan's experience.** (The idea is that if costs in the examples are uniform, employees will be better able to understand how cost sharing will work under the options they are considering.)

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Q32. I am worried that my employees will think the amounts shown in the examples are what the plan and they will pay if they actually have a baby or are treated for diabetes.

A32. The Coverage Examples sheet states in large print that it is not a cost estimator, and test groups apparently understood this. In any event, the agencies have considered the issue and believe this approach is best.

Providing the Glossary

Q33. What is the glossary?

A33. The glossary is a required, standard glossary of terms frequently used with group health plans.

Q34. Can I alter it to better fit my situation?

A34. No. If there is a significant difference between the plan's and the glossary's terms, you can address this on the SBC (presumably through a footnote). To reduce participant confusion, it may make sense to revise your plan's terminology to match the glossary terminology, when possible.

Q35. Must I provide copies of the glossary with the SBC?

A35. No, but you must:

- Tell participants at the bottom of the first page of the SBC where the glossary is posted (it can be on the employer's website, the insurer's website, or an agency website). The government 2017 version is posted at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf. The 2021 version is posted at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uniform-Glossary-11-2019.pdf.
- Mail a paper copy within seven business days after receiving a request for a paper glossary.

Distributing the SBC

Q36. Who is responsible for providing an SBC?

A36. The insurer is responsible for providing an SBC to the employer within seven days after the employer completes an application. The insurer and the plan administrator are each responsible for providing the SBC to participants, but only one of them needs to actually do it – they need to work out who will do the distribution. For self-funded plans, the plan administrator is responsible for providing the SBC. The plan administrator can hire others, like its TPA, to help, but the plan administrator is ultimately responsible. If an entity required to provide an SBC enters into a binding contract with another entity to provide the SBC, the following conditions must be met:

- The first entity must monitor the performance of the contract.
- The first entity must correct any noncompliance of the contract of which it becomes aware.
- If the first entity becomes aware of non-compliance that it cannot correct, it communicates with the individuals affected and takes significant steps to correct the non-compliance.

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Q37. Who must receive an SBC, and when?

A37. SBCs must be provided:

- At open enrollment
  - The SBC must be included with the open enrollment materials.
  - Only the SBC for the option the employee is currently enrolled in must be provided (if you would rather provide all SBCs instead, you may).
  - If the employee asks for the SBC for other options, those SBCs must be provided within seven business days.
  - SBCs must be provided to current employees, retirees (unless they are enrolled in a retiree-only plan) and COBRA beneficiaries.
- At renewal if there is no open enrollment
  - If the prior year's election simply carries over, the SBC for the employee's current coverage must be provided at least 30 days before the new plan or policy year. (If the plan or policy has not been reissued or renewed by then, the SBC is due as soon as possible after renewal/reissue, and in no event later than seven business days after either the new policy is issued or a written confirmation of an intent to renew is received.)
  - If the employee asks for the SBC for other options, those SBCs must be provided within seven business days.
  - SBCs must be provided to current employees, retirees (unless they are enrolled in a retiree-only plan) and COBRA beneficiaries.
- At initial enrollment
  - The SBC for all options the employee may choose among must be provided with the enrollment materials.
  - If no enrollment materials are provided, the SBC for all options must be provided by the first day the new employee may enroll.
- At special enrollment
  - The SBC for the option the individual is enrolled in must be provided within 90 calendar days after enrollment as a special enrollee.
  - The SBC must be provided within seven business days after a request for the SBC, if sooner.
- With a material mid-year change (see Q&A 27)
  - 60 days before the effective date of the change.

To prevent duplication, if a plan or issuer provides an SBC prior to application for coverage, the plan or issuer is not required to automatically provide another SBC upon application, if there is no change to the information required to be in the SBC. If there is a change, then the plan or issuer

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must update and provide a current SBC as soon as practicable upon receipt of the application, but no later than seven days after receipt. Furthermore, if the terms of coverage are still being negotiated after an application has been filed and SBC information changes, the plan or issuer is not required to provide an updated SBC until the first day of coverage (unless it is requested, in which case, the seven days rule applies).

Q38. What does “within seven business days” mean?

A38. The SBC must be postmarked, faxed or emailed by the close of the seventh business day after the request is received. (A response to a request for a paper copy must be mailed or faxed. If a request for an SBC is made electronically, the SBC can be provided electronically, with the usual statement that free paper copies can be requested.)

Q39. Do I need to provide an SBC to covered family members?

A39. A separate SBC does not need to be provided to covered family members unless you are aware that a family member lives at another address. In that case, the person living away needs his or her own SBC.

Q40. Can I include the SBC in my SPD?

A40. You may include the SBC in the SPD as long as:

- It is prominently displayed – for example, right after the table of contents or introduction; and
- The entire SBC is inserted, without adding any material between its pages or sections or deleting any part of the SBC.

Q41. Can I provide the SBC electronically?

A41. It depends on the situation.

If enrollment is exclusively online, the SBC can be provided online.

If enrollment is not exclusively online, there are different rules for new enrollees and current participants:

- For new enrollees:
  - The SBC must be reasonably accessible (for example, posted on the employer’s intranet or website).
  - The employee must be notified that the SBC is available, where it is located (with the Internet address or a link) and that a paper copy is available at no cost, with contact information to request a paper copy.

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- For enrolled employees:
  - If the employee regularly uses a computer as part of his or her job, the SBC or notice of where the SBC is posted must be sent to the computer the employee regularly uses, with an explanation of the significance of the SBC and that a paper copy is available at no cost with contact information to request a copy.
  - If the employee does not regularly use a computer as part of his or her job, the SBC may not be provided electronically.
- For enrolled retirees, COBRA participants and special enrollees who do not live with the employee:
  - The person must provide consent to email the SBC/plan materials and provide his or her email address.
  - If the person does not provide the consent and email address, the SBC may not be provided electronically.

An individual must always have the option to receive a paper copy upon request.

Q42. Is there sample notification language?

A42. Yes. The agencies have provided sample language (which you may, but are not required to, use).

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).

Q43. How may I provide notice that the SBC is available electronically?

A43. The notice that the SBC is available electronically can be mailed (many employers send a postcard) or emailed (with a “return receipt” feature).

Q44. If I provide SBCs electronically, can I display the SBC on a single web page with scrolling features, allow sorting by feature, and/or widen columns?

A44. Yes, as long as a paper version with the pages set up as required is available. Columns and rows may not be deleted unless the agencies specifically allow this (as they have done with deleting the annual limits row in 2014 and 2015).

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Other Languages

Q45. Are there requirements to provide the SBC in languages other than English?

A45. Yes. Similar to the requirement to provide SPDs in languages other than English in certain situations, the SBC must be provided in Chinese, Navajo, Spanish and Tagalog if issued in counties where more than 10 percent of the population is literate only in one of these languages.

The English version of the SBC distributed in those counties must disclose the availability of language services on the page of the SBC that includes the "Your Rights to Continue Coverage" and "Your Grievance and Appeals Rights" sections. The DOL has provided this sample language:

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].

Q46. Can I include the information about language assistance services even if the SBC is being provided in a county that does not need to include this disclosure?

A46. Yes.

Q47. How can I determine if I have employees in a county that need a translated version?

A47. The Department of Health and Human Services has posted a list of the counties that meet the 10% threshold at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CLAS-County-Data_Jan-2016-update-FINAL.pdf.

Q48. Are translated versions of the SBC and glossary available?

A48. Yes, for plan years beginning on or after April 1, 2017. You can access them at http://cciio.cms. gov/resources/other/index.html#sbcug.

Other Disclosure Requirement and Penalties

Q49. Does this replace my SPD, certificate or any summary I usually provide at open enrollment?

A49. No, the SBC does not replace your SPD or certificate. If you already provide a summary of benefits, you can continue to provide it and also provide the SBC, but you cannot provide anything instead of the SBC.

Q50. My state also has disclosure requirements. Must I follow them, too?

A50. If a state imposes additional requirements, those requirements also must be met (possibly in a separate document due to the strict formatting rules that apply to SBCs).

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Q51. What happens if I don't provide an SBC?

A51. There is a penalty of up to $1,000 per employee for willful (deliberate) failures to provide the SBC for violations that occurred on or before November 2, 2015 (regardless of when the penalty is imposed), and for penalties imposed on or before August 1, 2016. The penalty amount is $1,087 for penalties imposed after August 1, 2016, and on or before January 13, 2017. The penalty amount is $1,105 for penalties imposed after January 13, 2017, and on or before January 2, 2018. The penalty amount is $1,128 for penalties imposed after January 2, 2018, and on or before January 23, 2019. The penalty amount is $1,156 for penalties imposed after January 23, 2019. The penalty amount is $1,176 for penalties imposed after January 15, 2020. In addition, a $100 per participant per day excise tax may apply to each individual to whom such failure relates.

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