Summary of Benefits and Coverage (SBC)
Frequently Asked Questions (FAQs)

Updated April 2024

The Affordable Care Act (ACA) requires group health plans to provide enrolled and otherwise eligible individuals with a uniform "Summary of Benefits and Coverage" (SBC) describing the benefits and limitations of coverage under each plan option. This SBC distribution requirement applies at each annual open enrollment and at certain other times. It is intended to help benefits-eligible employees, under age 65 Retirees (early Retirees) and COBRA beneficiaries compare their employer-provided medical benefit options and other available coverage options.

There are strict requirements regarding the content and distribution of SBCs. HealthTrust annually prepares an SBC for each of the HealthTrust medical benefit plan options (including prescription drug coverage) currently offered by our Member Groups. We post the relevant SBC(s) on HealthTrust's Secure Member Portal prior to the open enrollment period for each annual (January or July) renewal. **Each Member Group, as the employer, must distribute the applicable SBC(s) in either paper (double-sided) or electronic form to eligible employees, under age 65 Retirees and COBRA beneficiaries beginning on the first day of the annual open enrollment period for their January or July renewal.** The SBCs are now linked in the digital benefit education packets as well.

Given that HealthTrust and the Member Group, as the employer, have responsibilities to ensure compliance with these SBC distribution requirements, we will need to collaborate to succeed. The following FAQs are designed to answer some of the questions that have arisen about the SBC requirements. In addition, HealthTrust will periodically provide Member Groups with information on the SBC distribution requirements, including when HealthTrust provides SBCs to Groups prior to the open enrollment period for the Group's annual renewal.

If you have questions about the FAQs or the SBC requirements, please contact your HealthTrust Benefits Advisor at 800.527.5001.

Disclaimer

These *Frequently Asked Questions* are provided for general informational purposes. They are not intended as and do not constitute legal advice. The information contained herein should not be relied upon or used as a substitute for consultation with legal, accounting, tax and/or other professional advisors. Questions regarding specific issues should be addressed to those advisors.

Q1: What group health plans are subject to the SBC requirements?

Employer Groups whose health plans are subject to the ACA are required to furnish SBCs to enrolled and otherwise eligible individuals. In general, this includes any plan offering group medical (including prescription drug) coverage. An SBC does not have to be provided for Retiree-only plans (such as Medicomp Three and effective January 1, 2025, the HealthTrust Medicare Advantage with Prescription Drug (MAPD) plan) or other "excepted" benefit plans (for example, stand-alone dental or vision plans, Health FSAs, etc.).

Q2: When did the SBC requirements first become effective?

The SBC rules initially became effective for plan years beginning in 2013.

Q3: What does an SBC look like?

Please see the sample SBC template here. The SBC template is updated periodically for any required changes. HealthTrust uses the current template in preparing SBCs for all HealthTrust medical benefit options that are subject to the SBC requirements.

Q3a: What are the changes to the SBCs for the 2024 Plan Year?

There are no federal changes to the SBC template or the related uniform Glossary of health coverage and medical terms for the 2024 Plan Year.

Q4: How will HealthTrust support the preparation and distribution of SBCs?

HealthTrust will prepare and distribute SBCs to Member Groups offering one or more HealthTrust medical benefit options in the following instances:

- Upon Annual Renewal/Open Enrollment (January or July). Annually, HealthTrust will prepare and make available electronically to your Group's designated Benefits Administrator(s) an SBC **for each HealthTrust medical benefit option** (including prescription drug coverage) that the Member Group is then currently offering. This will occur by the end of October for Groups with a January renewal. Groups with a July renewal will receive the SBCs by the end of April. In addition, in order to help Member Groups identify the individuals enrolled in each benefit plan option, we will provide a census with respect to each SBC, listing names of employees, as well as the names and addresses of COBRA beneficiaries and under age 65 Retirees (early Retirees) who are currently enrolled in that plan option.
- Upon Changing or Adding a Plan Option During Renewal. We will prepare and electronically provide the SBC for the new plan option no later than seven (7) business days from HealthTrust's receipt of the Member Group's written notice of a plan change or addition of a new plan option.
- Upon Material Modification of a Plan During a Plan Year. We will prepare and electronically provide Member Groups with the SBC reflecting the new plan coverage no later than seven (7) business days from HealthTrust's receipt of written notice of a mid-year plan change or addition of a new plan option.
- Upon Request. We will provide the Member Group with an SBC for any medical benefit option currently offered by HealthTrust upon written request no later than seven (7) business days following receipt of the request.

Please note: Employers may need to supplement the SBC template with additional information unique to their particular plan coverages, such as a description of any employer funding of plan deductibles or other cost sharing through Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs). If no additional information is needed, then the employer may simply distribute the SBC to eligible individuals. Please see Q18 and Q19 for additional information.

Q5: When does the employer have to provide SBCs to eligible individuals?

The regulations require that the SBC be provided in writing, in either paper (double-sided) or electronic form and free of charge in several instances:

- Upon Initial Eligibility/Enrollment. For new hires and newly eligible employees, the SBC must be provided when a plan distributes written enrollment/application materials to these individuals. For this purpose, written enrollment/application materials include any forms or requests for information (in either paper or electronic form) that must be completed for enrollment.
- Upon Annual Renewal/Open Enrollment.
    - If the Member Group provides open enrollment materials (i.e., any written enrollment/application materials) to eligible employees, under age 65 Retirees and COBRA beneficiaries, the Group must provide SBCs to those individuals when distributing the open enrollment materials. This should occur on the first day of the open enrollment period.
    - If the Member Group does not provide open enrollment materials, the SBC must be provided to eligible employees, under age 65 Retirees and COBRA beneficiaries at least 30 days prior to the annual renewal date of January 1 for January Groups or July 1 for July Groups.
    - If the Member Group offers a choice of plan options, the Group must automatically provide currently enrolled employees, under age 65 Retirees and COBRA beneficiaries with an SBC only for the plan option in which they are enrolled. These Enrollees also must be provided SBCs for other plan options upon their request.
    - Employees who are eligible for but not currently enrolled in a Member Group medical benefit plan must be provided with SBCs for all plan options for which they are eligible.
- Upon HIPAA Special Enrollment. A HIPAA special enrollment is when an employee or a dependent loses coverage under another group health plan and is eligible to be added to the employer's plan. For example, this can happen if an employee and spouse lose coverage under another employer's plan due to the spouse ending employment. In these situations, the SBC must be provided to the new Enrollee within 90 days following the effective date of coverage.
- If There are Changes to the SBC. If there is any change in the SBC that was previously provided upon initial application or with open enrollment materials and before the first day of coverage, an updated SBC must be provided no later than the first day of coverage.
- Upon Request. The SBC must always be provided upon request as soon as practicable but not later than seven (7) business days following receipt of the request.
- Upon a Material Modification of the Plan During a Plan Year. If a material modification is made to the plan during the plan year (i.e., other than at annual renewal) a notice of the change or a new SBC must be provided **no later than 60 days before the effective date of the change**. A "material modification" generally means a change to a plan or plan option that would change information in an existing SBC, and may include either an enhancement or reduction in services or coverage. If a new SBC is needed due to the change, the Member Group must notify their HealthTrust Benefits Advisor in writing to obtain the appropriate SBC.

  Upon material modifications that occur during a plan year with a mid-year open enrollment allowed: A new SBC or Notice of the plan change must be provided when enrollment materials are distributed **but no later than 60 days in advance** of the effective date of the plan option change.

  This requirement may significantly impact implementation of plan changes.

For example:

- Town meeting vote – The Town passes a plan change at town meeting on March 14, but must provide a 60-day advance notice to employees. A new SBC or Notice of plan changes must be distributed by April 1 for the plan change to be effective on June 1.
- Bargained agreements – A collective bargaining agreement is being negotiated for a September 1 effective date. The agreement must be approved and a new SBC or Notice of plan changes must be distributed by July 1 in order to implement the changes effective September 1.

Upon material modifications that occur during a plan year with no mid-year open elections allowed: A Notice of the plan change must be provided **at least 60 days in advance of** the effective date of the change, but a new SBC is not required until the next renewal.

Q6: What happens if the employer changes a plan option or adds a new plan option during renewal?

If a Member Group changes or adds a plan option effective upon the plan renewal date (January 1 or July 1) the Group must notify the HealthTrust Benefits Advisor in writing as soon as possible but no later than 30 days prior to the renewal date. HealthTrust will prepare and electronically provide Member Groups with the SBC for the new plan coverage within seven (7) business days from HealthTrust's receipt of the notice. When the Member Group receives the new SBC from HealthTrust the Group must distribute the SBC to eligible employees, under age 65 Retirees and COBRA beneficiaries in accordance with the rules described in Q4 above "Upon Renewal/Open Enrollment."

If a Member Group receives the new SBC less than 30 days before the renewal date, it should be distributed to eligible individuals as soon as possible but no later than seven (7) business days of receiving it from HealthTrust.

Q7: If the employer offers more than one benefit option, does every eligible employee need to be provided with a new SBC for each option every year at open enrollment?

For employees who are enrolled in a medical benefit option, the requirement is to provide a new SBC automatically at open enrollment, but only for the benefit option in which a person is currently enrolled. Employers do not have to automatically provide SBCs for benefit options in which the individual is not enrolled. However, if a person requests an SBC with respect to one or more other benefit option(s) for which the individual is eligible, the SBC(s) must be provided as soon as practicable, but no later than seven (7) business days following the individual's request.

Employees who are eligible for but not currently enrolled in your Group medical plan must be provided with SBCs for all benefit options for which they are eligible.

Q8: Does the SBC have to be provided to every eligible family member or can the SBC be provided to just the employee?

A separate SBC **does not** have to be provided to every member in a family. A single SBC may be provided to an employee (or under age 65 Retiree or COBRA beneficiary) for all eligible family members unless a Group knows that a family member has a different address, in which case a separate SBC must be provided to the dependent's last known address. If the employer does not know that a dependent lives at another address, they can assume the dependent lives with the employee. In addition, employees do not have to be surveyed to verify dependent addresses.

Q9: Can the SBC be distributed with other enrollment or plan related materials?

Yes. The SBC can be distributed with other materials (such as enrollment forms, cost sharing summaries or other employer provided documentation) as long as the SBC is provided as a stand-alone document. HealthTrust will continue to provide Member Groups with the cost sharing schedules and benefit summaries as we have in the past. The SBCs are now linked in the digital benefit education packets as well.

Q10: Can the SBC be sent electronically (by email) or posted to a website?

Yes. The SBC generally may be delivered by the employer to its benefits-eligible employees (or under age 65 Retirees or COBRA beneficiaries) electronically if:

- The format is readily accessible by the employees;
- When the electronic form is a website posting (either internet or intranet), the employer advises the employees in paper form or by email that the documents are on the internet/intranet and provides the address;
- The electronic form, such as an email with an attachment, can be electronically retained and printed;
- The SBC is placed in a location that is prominent and readily accessible;
- The SBC is consistent with the appearance, content and language requirements of the regulations; and
- The employee is notified that the SBC is available in paper form, free of charge, upon request.

The specific rules for electronic distribution of SBCs can be found in the 2015 SBC final regulations at 45 CFR Section 147.200(a)(4). See also Q10 of ACA FAQs Part VIII here and Q1 of ACA FAQs Part IX here.

Q11: How can employees be notified that the SBC is electronically available?

Employees can be notified either by paper or by email stating that the SBC is available electronically. The use of payroll stuffers or postcards is permissible. If an email notification process is to be used, Employers must first obtain consent from the person to receive the SBC by email and must make sure that all recipients have access to the electronic site where the SBCs will be available or can readily open an attachment with the SBC.

Q12: Has the Department of Labor provided model language to meet the requirement to provide an email or postcard in connection with website postings of the SBC?

Yes. Plans have flexibility with respect to this language and may choose to tailor it in many ways. One example from the Department of Labor is:

> **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 {Your Website}. A paper copy is also available, free of charge, by calling {Your Telephone Number}.*

Q13: Does a paper copy of the SBC have to be provided upon request?

Yes. Upon request, the SBC must be provided in paper form (double-sided) and free of charge, as soon as practical but no later than seven (7) business days after the request.

Q14: Are there penalties for not complying with the SBC requirement?

Yes. The ACA provides that an entity that willfully fails to provide an SBC in accordance with the requirements of the law shall be subject to a fine of not more than $1,406 for 2024 (as adjusted annually under 45 CFR part 102) for each such failure. A separate fine may be imposed for each individual for whom there is a failure to provide an SBC. The U.S. Department of Health and Human Services has penalty enforcement authority over non-federal governmental plans. See Public Health Service Act Section 2715(f) and 45 CFR 147.200(e). Accordingly, employers should comply with the SBC distribution requirements, and written procedures and records of SBC compliance efforts should be maintained.

Q15: Are SBCs required to be provided to individuals who are COBRA beneficiaries?

Yes. During an open enrollment period, any COBRA beneficiary must be given the same rights to elect coverage that are also provided to similarly situated non-COBRA beneficiaries. Therefore, the SBC must be provided to any COBRA beneficiary. For more information, see Q8 of the FAQs About Affordable Care Act Implementation (Part VIII) here. Member Groups, as the employer, are responsible for distributing the SBC to any COBRA beneficiary. HealthTrust will assist Member Groups by providing a listing of COBRA beneficiaries and their addresses.

Q16: Are SBCs required to be provided to individuals enrolled in a "Retiree-only" plan such as Medicomp Three or the HealthTrust Medicare Advantage with Prescription Drug (MAPD) plan?

No. SBCs do not need to be provided with respect to plans that cover only Retirees and their family members. Therefore, Member Groups do not need to provide SBCs to Medicare-eligible Retirees who are covered by the Member Group's HealthTrust Medicomp Three plan, and effective January 1, 2025, the HealthTrust Medicare Advantage with Prescription Drug (MAPD) plan.

Q17: Are SBCs required to be provided to individuals who are early Retirees?

Yes. An SBC must be provided to under age 65 (non-Medicare) Retirees who are covered under a plan that also covers active employees. Most early Retirees are enrolled in such plans and therefore must receive an SBC because the plan is not a "Retiree only" plan. At renewal, HealthTrust will assist Groups by providing a list of early Retirees (who are enrolled in the relevant plan option) and their addresses.

If the Employer has a separate plan established solely for early Retirees, the Employer would not have to provide an SBC to those early Retirees.

Q18: Are SBCs required to be provided to individuals who are enrolled in a Health Savings Account (HSA)?

HSAs are generally not subject to the SBC requirements because they are not considered separate group health plans. Therefore, a separate SBC is not required for an HSA. However, employers who offer a high deductible plan that includes an HSA should supplement the SBC for that plan with information describing the HSA component.

Q19: Are SBCs required to be provided to individuals who are enrolled in a Health Reimbursement Arrangement (HRA)?

The SBC regulatory guidance provides that a separate SBC is not required for an HRA that is "integrated" with an employer's group medical plan. Under IRS Notice 2013-54 (issued September 13, 2013), an HRA generally will be considered "integrated" with an employer group medical plan only if:

- The employee is eligible to enroll in the employer's group medical plan;
- The employee is enrolled in a group medical plan (whether or not it is the employer's);
- The HRA only funds deductibles, coinsurance and/or copays under the group medical plan (other medical expenses may be funded if the group medical plan meets the minimum value requirements of ACA); **and**
- The employee is allowed to opt out of the HRA at least annually and upon termination of employment.

Most HRAs will be considered "integrated" under these rules and, therefore, no separate SBC is required. Employers, however, should supplement the SBC for the primary group medical plan with information describing the HRA funding component. For example, the employer should provide information regarding the extent to which the employer will fund a portion of a plan deductible through an HRA.

Benefit Advantage HRAs - SBCs for 2024 plan year medical plans that are integrated with an HRA administered through HealthTrust's Benefit Advantage service will continue to include general references to the HRA component. However, the employer will still need to supplement the SBC with specific information regarding any HRA funding available to eligible employees. Your Group's "HRA Benefit and Claims Process Overview" provided by HealthTrust during the Benefit Advantage HRA implementation/renewal process or your Group's own HRA summary may be used for this purpose.

Q20: Are SBCs required to be provided to individuals who are enrolled in a Health Flexible Spending Account (Health FSA)?

No. An SBC is not required for a Health FSA that provides only "excepted benefits" under federal regulations. See 45 CFR 146.145(c)(3)(v). In general, a Health FSA will be considered to provide only excepted benefits for a class of employees if:

i. The employer offers group medical plan coverage (in addition to the Health FSA) to the class of employees for the year; **and**

ii. The Health FSA is funded solely with employee salary reduction contributions and/or employer contributions that do not exceed $500.*

**Some Health FSAs include a feature under which employee salary reduction contributions are matched by employer contributions. If your plan provides an employer match, employer contributions may not exceed the greater of $500 or the amount of the employee's salary reduction contributions.*

Under ACA requirements, all Health FSAs must provide only "excepted benefits" effective for 2014 or later plan years. Therefore, there is no separate SBC required with respect to Health FSAs.

Q21: What is the Glossary referenced in the SBC?

SBC regulations require that all individuals eligible for your Group medical plan coverage have access to a uniform Glossary of health coverage and medical terms. The purpose of the Glossary is to provide uniform definitions of certain medical terms commonly used in regard to health plan coverage. This Glossary is standard for all plans and each SBC will provide a website where the Glossary may be accessed and a toll-free phone number for requesting a

paper copy. Specific terms that are defined in the Glossary are underlined in each SBC and those terms can be directly hyperlinked from an electronic SBC to the Glossary.

Q22: Are there Language Access requirements that apply to SBCs and their distribution?

SBC regulations require that SBCs must be provided in a culturally and linguistically appropriate manner. This means that certain language assistance must be provided if ten percent or more of the population in any county speaks only a specific language other than English. Guidance to date indicates that this is not true for any New Hampshire county, except for Hillsborough County. We recommend checking census.gov if you are unsure.

Q23: Where can I find more guidance and information about the SBC requirements?

In June 2015 the federal agencies issued updated final regulations regarding the SBC requirements which apply for plan years beginning in 2016 and beyond. We recommend that you review these 2015 final regulations which can be found at 45 CFR Section 147.200. Related SBC guidance can be found here.

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