Summary of Benefits and Coverage

Frequently Asked Questions for Employers

Disclaimer

We share this information with our clients and friends for general informational purposes only. It does not necessarily address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues and application of these rules to your plans should be addressed by your legal counsel.

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Contents

Effective Date and Timing Requirements 1

1. In what instances must SBCs be provided? 1

2. What happens if the plan terms change mid-year? 2

3. What happens if negotiations with our insurer are not completed until we are already within 30 days of the renewal date and as a result, the insurer does not provide the SBC on time? 2

Creating the SBC 3

4. Who is responsible for completing the SBC? 3

5. When will my insurer provide the employer and participants with the SBC? 3

6. My plan has multiple plan options. Can I combine them and create one SBC? 3

7. What if my plan has multiple tiers of coverage (e.g., employee-only, employee plus spouse, family coverage, etc.) or varying levels of co-pays, deductibles and coinsurance? Do I have to create a separate SBC for each option? 3

8. We already provide a summary comparison chart illustrating the differences between our plan options. Is it permissible to combine SBC elements to provide a side-by-side comparison, instead of a separate SBC for each option? 4

9. Do we have to provide an SBC for our dental or vision coverage? What about retiree and Medicare coverage? 4

Content Requirements 4

10. What is the required content for an SBC? 4

11. What is the Uniform Glossary? 5

12. What are the coverage examples? 5

13. Can the appearance of the SBC template be altered? 5

14. What if my plan cannot reasonably be described using the SBC templates as provided by the Department? 6

15. What if our plan has carved out a certain benefit that is managed by another party (such as a pharmacy benefit manager (PBM))? 6

16. What must a plan or issuer do when a plan uses two or more insurance products provided by separate insurers? 6

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17. In addition to our primary medical plan, we have a health flexible spending account (which is an excepted benefit) and a wellness program. How do these "add-ons" affect our SBC requirements? ... 7

18. Our organization has several employees who are fluent only in a non-English language. Do we have to provide a translated version of the SBC in their non-English language to them? ... 7

Delivery Requirements ... 7

19. Who must be given an SBC? ... 7

20. Are we required to provide SBCs to individuals who are COBRA qualified beneficiaries? ... 8

21. Can we include the SBC with other participant materials? ... 8

22. Can an SBC be provided online? ... 8

23. In addition to two SBC-specific safe harbors for online distribution, are there other compliant methods of providing SBCs electronically? ... 8

24. What is the DOL general safe harbor provision for disclosure through electronic media? ... 9

25. What does the safe harbor require for electronic distribution to individuals without work-related access? ... 9

26. What does the general safe harbor require for posting the required disclosure on our intranet or company website? ... 10

27. Is there sample language for the e-card or postcard for posting the SBC on a website for those who are eligible but not on the plan? ... 11

28. What are the electronic distribution rules for self-insured nonfederal governmental plans? ... 11

Noncompliance ... 11

29. What is the penalty for failure to provide an SBC? ... 11

Additional Information ... 13

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The Patient Protection and Affordability Care Act (ACA) created two new required disclosures: the Summary of Benefits and Coverage (SBC) and the Uniform Glossary. The purpose of these disclosures is to have uniformity in coverage summaries and to better educate participants and beneficiaries about health plan coverage and costs in both the individual and group markets. SBCs are required for most health plans (other than “excepted benefits,” retiree-only plans, and Medicare Advantage plans), regardless of funding type and grandfathered status. The disclosure requirements apply *in addition to* ERISA’s other required disclosures: Summary Plan Description (SPD), Summary of Material Modification (SMM), and Summary of Material Reduction (SMR). SBCs and the Uniform Glossary are regulated by three agencies: The Departments of Labor, Treasury, and Health & Human Services (collectively, the Department).

The SBC can be provided as a stand-alone document or part of the enrollment materials as long as it is intact and prominently displayed at the beginning of the materials. The SBC must conform to the content and appearance requirements of a Department-provided template and must use terminology understandable by the average plan enrollee.

These Questions and Answers for Employers are intended to assist employer-sponsors of group health plans in understanding the requirements.

Effective Date and Timing Requirements

1. In what instances must SBCs be provided?

n SBC must be provided in five situations. Note that the first three are linked to an enrollment opportunity because the SBC is intended to help participants understand and compare plans at the time they choose coverage:

1) **Open enrollments**: The SBC must be provided with written enrollment materials, or if there are no written enrollment materials, the SBC must be provided no later than the first day of the enrollment opportunity (e.g., by the first day of annual enrollment). If the plan has an evergreen enrollment (i.e., participants are automatically re-enrolled every year), the SBC must be provided 30 days prior to start date of the new plan year.

   For participants and beneficiaries who are already enrolled in coverage, it is only necessary to provide them with the SBC for the coverage in which they are enrolled. If they request an SBC for another plan for which they are eligible, one must be provided within seven business days. Unenrolled individuals must receive SBCs for each plan for which they are eligible.

2) **New enrollments**: An SBC for all benefit options available to an eligible employee or beneficiary must be included with any written enrollment materials. If the plan does not provide written materials, then the SBC(s) must be provided no later than

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the first day the participant and any beneficiaries are able to enroll.Unenrolled individuals must receive SBCs for each plan for which they are eligible.

3) **Special enrollments**: The SBC for the plan in which the individual enrolled under a Special Enrollment must be provided automatically within 90 days of enrollment, or within seven business days if requested prior to enrollment. If the special enrollment relates to an employee who was previously eligible for coverage, but waived participation in a health plan option, the event is treated as a new enrollment and the SBC should be provided simultaneously with enrollment materials in such cases.

4) **On Request**: If a participant or beneficiary requests an SBC, it must be sent as soon as practicable, but no later than seven business days after the request.

5) **Notice of Modification**: If there is a midyear material modification made to the plan that affects the information contained in the SBC, an updated SBC (or standalone notice) must be provided at least 60 days **prior** to the effective date of the change. (Note the difference between this advanced notification rule and the more relaxed timing rules for providing an SMM or SMR.)

2. What happens if the plan terms change mid-year?

If a midyear material modification or reduction is made to a plan that affects the information contained in the SBC, an updated SBC (or standalone notice) must be issued at least 60 days before the modification or reduction takes effect. If you provide the SBC in a timely manner, it will also satisfy your obligation to provide an SMM as required under ERISA.

Note: Federal regulators have indicated that they will not take action against plans that adopt modifications to provide greater coverage for COVID-19 diagnosis or treatment without providing the minimum 60-day advance notice to enrollees, but notice of the change must be provided to participants as soon as reasonably practicable.

3. What happens if negotiations with our insurer are not completed until we are already within 30 days of the renewal date and as a result, the insurer does not provide the SBC on time?

If the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but not later than 7 business days after issuance of the new policy or certificate of insurance, or the receipt of written confirmation of your intent to renew, whichever is earlier.

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Creating the SBC

4. Who is responsible for completing the SBC?

For insured plans, the insurer will complete the SBC. For self-insured plans, the plan sponsor (typically, the employer) is responsible for the SBC. The information and codes needed to complete the coverage examples (discussed in Q&A 12 below) usually resides with the party that processes plan claims. Self-insured plans administered by third-party administrators (TPAs) will frequently use and distribute the SBCs created by the TPAs, although they may wish to modify the TPA's version to reflect the employer's own branding.

5. When will my insurer provide the employer and participants with the SBC?

The insurer is required to provide the employer with an SBC at the time of application, or as soon as practicable upon receipt of application, but in no case later than 7 business days following the application for coverage. Depending on the agreement made with the insurer, the insurer may also have responsibility for distributing the SBC to eligible individuals in the plan, in which case, the insurer fulfills the SBC requirement for both the insurer and plan sponsor. If the insurer is responsible for providing the SBC, the carrier must adhere to the same SBC timing, appearance and distribution requirements. Because both the plan and the insurer have responsibility for providing participants and beneficiaries with an SBC, the delegation of responsibility between the plan and the insurer must be in writing and both parties are required to take action if the party assuming responsibility fails to fulfill its obligations.

6. My plan has multiple plan options. Can I combine them and create one SBC?

No. If an individual is able to choose among different plan options (for example, among a PPO without dental coverage, a PPO that includes dental coverage, and an HMO), then a separate SBC must be created for each option (in our example, three SBCs).

7. What if my plan has multiple tiers of coverage (e.g., employee-only, employee plus spouse, family coverage, etc.) or varying levels of co-pays, deductibles and coinsurance? Do I have to create a separate SBC for each option?

No, a plan does not have to create separate SBCs for different tiers of coverage or different levels of deductibles, co-pays, and coinsurance. The information about different tiers can be included in a single SBC, as long as the appearance is understandable. (Note that the instructions for completing coverage examples state that employers should generate cost sharing information (e.g., deductible and out-of-pocket limits) for the self-only tier only.)

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8. We already provide a summary comparison chart illustrating the differences between our plan options. Is it permissible to combine SBC elements to provide a side-by-side comparison, instead of a separate SBC for each option?

This will not satisfy the SBC requirements. Providing such a tool is permissible, but the full SBC for each benefit option must still be provided as described under the rules and in accordance with the Department-prescribed template.

9. Do we have to provide an SBC for our dental or vision coverage? What about retiree and Medicare coverage?

You will not have to provide an SBC for your dental or vision coverage if they are excepted benefits, such as stand-alone dental and vision plans. Stand-alone dental and vision coverage are excepted benefits if participants may decline the coverage or if the claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan. Note that this rule would permit an employer to use the same party to process medical and dental claims (for example) provided that there are separate administrative contracts. It is no longer required that an individual pay a separate premium for the dental or vision coverage to classify the coverage as "excepted." SBCs are not required for retiree-only coverage or for Medicare Advantage plans.

Content Requirements

10. What is the required content for an SBC?

In accordance with the template and instructions, the SBC must include the benefits and limitations of the plan option, including, but not limited to the following:

- Description of coverage, including cost sharing provisions, such as coinsurance, deductible, and copay obligations;
- Coverage exceptions, reductions and limitations;
- Contact information such as a telephone number for customer service and a web address for obtaining copies of the insurance policy or certificate, if applicable;
- An internet address linking individuals to the Uniform Glossary;
- An internet address linking individuals to information about their prescription drug coverage if a formulary is used;
- An internet address (or similar contact information) for obtaining a list of network providers;
- Renewability and continuation of coverage provisions;
- A statement that the SBC is only a summary of the plan document, insurance policy, or certificate of insurance, which should be consulted to determine the governing contractual provisions of coverage;

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- Coverage examples that include out-of-pocket costs for hypothetical treatment plans (having a baby, Type II diabetes, and a simple fracture); and
- Statements of whether the plan or coverage provides minimum essential coverage and whether the plan or coverage meets minimum value requirements.

11. What is the Uniform Glossary?

The Uniform Glossary is a list of commonly used medical and insurance terms and their definitions, and its purpose is to educate participants and beneficiaries about their plan. The employer or insurer is not required to provide the Uniform Glossary except upon request, in which case the employer or insurer has seven business days in which to provide it. The SBC must include a website address for the Uniform Glossary: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf. Using the Department of Labor website means individuals will find the latest version of the Uniform Glossary.

12. What are the coverage examples?

The coverage examples are a required section of the SBC intended to show participants and beneficiaries the plan coverage and out-of-pocket costs of a hypothetical treatment plan for having a baby, managing Type II diabetes, and a simple fracture. Because all plans (including Marketplace plans) will generate examples for the same hypothetical treatment, the completed examples are intended to allow a specific apples-to-apples comparison of out-of-pocket costs. The Department has published an on-line calculator that plans and issuers can use to input cost information about the plan, in order to generate the required information for the coverage examples.

13. Can the appearance of the SBC template be altered?

Very little. Generally, a plan's SBCs must be based very closely on the Department template, with a few permitted variations as follows:

- Employers can use their own logos, provided the logo identifies the plan sponsor or issuer;
- Minor adjustments can be made to row and column size, but they cannot be moved or removed;
- Barcodes or control numbers can be added for quality control purposes;
- The SBC can be printed in color or grayscale; and
- A statement about whether the plan is grandfathered may be added at the end of the SBC.

Additionally, the OMB control numbers that appear on the Department templates must be removed.

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14. What if my plan cannot reasonably be described using the SBC templates as provided by the Department?

The instructions provide that if the plan's terms cannot reasonably be described in a manner consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its "best efforts" to do so in a manner that is still as consistent with the instructions and template format as reasonably possible.

15. What if our plan has carved out a certain benefit that is managed by another party (such as a pharmacy benefit manager (PBM))?

Different combinations of plans and providers may have different information necessary to create an SBC. The Department stated that a plan sponsor or issuer will not be subject to any enforcement action for failing to timely provide an SBC, provided certain requirements are met. This relief applies where the plan or health insurance issuer has contracted with another party (e.g., the PBM), and the other party has assumed responsibility for: (1) completing the SBC; (2) providing required information to complete a portion of the SBC; and/or (3) delivering an SBC with respect to certain individuals in accordance with the final regulations.

The following conditions must also be satisfied when the responsibility for completing or delivering an SBC is contracted out:

- The plan or issuer monitors performance under the contract;
- If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer has the information to correct it, it is corrected as soon as practicable (such as by providing the SBC); and
- If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer does not have the information to correct it, the plan or issuer communicates with participants and beneficiaries regarding the lapse and begins taking significant steps as soon as practicable to avoid future violations.

16. What must a plan or issuer do when a plan uses two or more insurance products provided by separate insurers?

A single party (usually the employer) has the option of synthesizing the SBC information from various parties into a single SBC. However, it is also permissible for each of the responsible parties to send separate SBCs for the separate portions of the plan (e.g., insurer sends SBC for its benefits, employer sends SBC for its benefits). When this approach is used, the employer should communicate to eligible individuals, via a cover letter or a notation on the SBC, that the plan provides coverage using multiple different insurers who will each provide an SBC, and that those wanting assistance in understanding how the plan benefits work together may contact the plan administrator for more information, along with contact information.

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17. In addition to our primary medical plan, we have a health flexible spending account (which is an excepted benefit) and a wellness program. How do these "add-ons" affect our SBC requirements?

Plans and issuers are permitted (but not required) to combine the information into one SBC, provided the appearance is understandable. That is, the effects of such add-ons can be clearly noted in the appropriate spaces on the SBC for deductibles, copays, coinsurance, and benefits otherwise not covered by the primary medical coverage. In such circumstances, the coverage examples should note the assumptions used in creating them.

18. Our organization has several employees who are fluent only in a non-English language. Do we have to provide a translated version of the SBC in their non-English language to them?

If SBCs are sent to participants and beneficiaries in counties where the U.S. Census Bureau has determined that 10% or more of the population in that county is literate only in a non-English language, the plan (or the insurer) must provide support services in a "culturally and linguistically appropriate" manner. To satisfy this requirement, SBCs sent to those counties must include a statement, prominently displayed, in the applicable non-English language clearly indicating how to access the language services provided by the plan or insurer. In turn, the plan (or insurer) must provide support services, such as a telephone customer service hotline, that can answer questions and be able to assist participants and beneficiaries in the non-English language. Currently there are four languages: Spanish, Chinese, Tagalog, and Navajo. Information on the counties meeting the 10% threshold is available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CLAS-County-Data_Jan-2016-update-FINAL.pdf. (as of January 1, 2021).

Finally, a translated SBC and Glossary in the applicable non-English language must be provided upon request. Written translations of the SBC template and Uniform Glossary in Spanish, Chinese, Tagalog, and Navajo are available on the CCIIO website here.

Delivery Requirements

19. Who must be given an SBC?

The SBC must be provided to all individuals eligible for coverage. However, under the SBC non-duplication provisions, it is necessary to provide a separate SBC to a beneficiary only if the beneficiary has an address on file that is different from the participant's (e.g., QMSCO altnernate recipients).

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20. Are we required to provide SBCs to individuals who are COBRA qualified beneficiaries?

The qualifying event itself will not usually trigger an SBC; however, after a qualified beneficiary elects to continue coverage, the qualified beneficiary is entitled to receive SBC(s) at the same times as a similarly situated non-COBRA beneficiary. There are also limited situations in which a qualified beneficiary may need to be offered coverage that is different from the coverage being received before the qualifying event, and this may also trigger the right to an SBC. Note that certain qualified beneficiaries will also have an address that is different from the participant's.

21. Can we include the SBC with other participant materials?

Yes. The SBC may be included with other plan summary materials (for example, an SPD). If the SBC is combined with other materials, it should be intact and prominently displayed at the beginning of the materials (such as immediately after the table of contents in a summary plan description). Many employers will find it easier to send the SBC as a stand-alone document.

22. Can an SBC be provided online?

Yes, there are a variety of circumstances under which SBCs may be provided electronically, including two SBC-specific safe harbors. The two SBC-specific safe harbors are:

- Employers who conduct online enrollment or online renewal (re-enrollment at open/annual enrollment) may provide the SBCs to participants and beneficiaries electronically in connection with the online enrollment. The individual must have the option to receive a paper copy upon request.
- An SBC may also be provided electronically to a participant or beneficiary who requests one online. Again, the individual must have the option to receive a paper copy upon request.

23. In addition to two SBC-specific safe harbors for online distribution, are there other compliant methods of providing SBCs electronically?

Yes, SBCs may also be provided electronically to individuals who are eligible, <u>but not yet enrolled</u>, if:

- The format is readily accessible (html, MS Word, or PDF format);
- The SBC is provided in paper form free of charge upon request; and
- If the SBC is provided via an internet posting, the plan or issuer timely advises the individuals that the SBC is available on the internet and provides the internet address. Plans or issuers may make this disclosure via e-card or postcard, via mail, or by email. See Q&A 27 below for sample language for the e-card or postcard.

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For participants and beneficiaries already enrolled, an SBC may be provided electronically by employers with health plans subject to ERISA, church plans, and fully insured nonfederal governmental plans as long as distribution is done in accordance with the DOL safe harbor provision for disclosure through electronic media. See Q&A 24 for more information. See Q&A 28 for information on self-insured nonfederal governmental employer-sponsored plans.

24. What is the DOL general safe harbor provision for disclosure through electronic media?

The DOL's general electronic disclosure regulations contain a "safe harbor" for distribution of many ERISA-required documents including SPDs, SMMs, and SBCs for all ERISA plans. The "safe harbor" applies to employees and to non-employees (such as COBRA qualified beneficiaries) entitled to disclosure. The regulations impose significant paperwork requirements for recipients of electronic disclosures who are not employees with work-related access to the electronic delivery system.

The regulations require plan administrators to take appropriate and necessary steps to make certain that the system for furnishing documents "results in actual receipt" of the transmitted information (e.g., using return-receipt or notice of undelivered e-mail features). In addition, to satisfy the safe harbor requirements, the following general requirements must be met for any recipient of electronic disclosures:

- The electronic materials must be prepared and furnished in accordance with otherwise applicable requirements;
- Notice must be provided to each recipient, at the time the electronic document is furnished, of the significance of the document and of the right to request and obtain a paper version of the document;
- A paper version of the electronic document must be available on request, and no charge may be imposed if the document in question is one that must otherwise be provided without charge (e.g., SPD); and
- The plan administrator must take reasonable and appropriate steps to safeguard the confidentiality of the information when a disclosure includes personal information relating to an individual's accounts and benefits.

Electronic distribution is permitted under the safe harbor for two classes of individuals: (1) participants with work-related computer access, and (2) consenting individuals with no work-related computer access. See Q&A 25 for more information.

25. What does the safe harbor require for electronic distribution to individuals without work-related access?

For participants without work-related access (e.g., employees for whom computer access is not an integral part of employment duties or non-employees such as COBRA qualified

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beneficiaries), disclosure may be made electronically (as long as the general conditions above in Q&A 24 are also met) and the individual provides an address for delivery of the documents and affirmatively consents to the electronic disclosure.

The consent may be given electronically. If the electronic disclosure will be made “through the Internet or other electronic communication system,” the individual must affirmatively consent “in a manner that reasonably demonstrates the individual's ability to access information in the electronic form that will be used.”

The consent must occur after the individual has been provided with a statement that explains:

- The types of documents that will be distributed electronically;
- That consent may be withdrawn without charge;
- The procedures for withdrawing consent and updating information (e.g., address for receiving electronic disclosure);
- The right to request a paper version and if a charge applies; and
- The electronic delivery system and what hardware and software will be needed to use it.

If system hardware or software requirements change, the plan administrator must provide a revised statement and obtain renewed consent.

However, if the disclosure will be made by “CD, DVD or similar media not dependent on electronic transmission,” the individual is *not* required to provide this kind of heightened consent (and need not provide an e-mail address).

26. What does the general safe harbor require for posting the required disclosure on our intranet or company website?

An organization may post the SBC disclosure on its intranet or organization website so long as its actions meet certain general “safe harbor” conditions. Under the general “safe harbor” conditions, a plan administrator must:

- Use appropriate and necessary means to ensure that posting the disclosure on a company's intranet or website results in “actual receipt” by plan participants;
- Prepare and distribute the disclosures in conformity with all applicable ERISA disclosure requirements (e.g., timing and format requirements);
- Provide a written or electronic notice to employees when the SBC is posted, which directs them to the intranet and describes
  - the significance of the disclosure and
  - the employee’s right to request a paper copy; and
- Provide a paper copy of the disclosure, without charge, upon request.

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The preamble of the regulations on the "safe harbor" indicate that taking "appropriate and necessary" measures to make sure the posting of disclosures on an organization's intranet or website results in actual receipt could include any of the following:

- Adding a prominent link on the company's homepage to the separate part of the company website or intranet that contains the disclosures;
- Providing directions on the website on how to replace a lost or forgotten password, if applicable; and
- Keeping the disclosures on the website or intranet for a reasonable time following notice to employees of the availability of the disclosures.

27. Is there sample language for the e-card or postcard for posting the SBC on a website for those who are eligible but not on the plan?

Yes, sample language has been provided by the Departments and is located here (FAQ 12).

28. What are the electronic distribution rules for self-insured nonfederal governmental plans?

Self-insured nonfederal governmental plans may choose to conform to either the substance of the provisions for ERISA Plans (described in Q&As 23 - 26) or the substance of the provisions applicable to issuers offering individual health insurance coverage. The alternative provisions for issuers offering individual health insurance coverage include:

- Email the SBC after obtaining the participants' or beneficiaries' agreements to receive the SBC or other disclosures by e-mail, or
- If Internet posting, notify the participant and beneficiaries by email or postcard that the SBC is available on the Internet (including internet address).
- The SBC form may be provided electronically if:
  - The SBC format is readily accessible (such as in an HTML, MS Word, or PDF format);
  - The SBC is placed in a location that is prominent and readily accessible;
  - The SBC is provided in a format that can be electronically retained and printed;
  - The SBC is consistent with appearance, content, and language requirements; and
  - Notification is made to the participant or beneficiaries that a paper form is available upon request at no charge.

Noncompliance

29. What is the penalty for failure to provide an SBC?

Insurers and plan administrators of insured plans, or plan administrators of self-funded plans, who "willfully" fail to provide an SBC, can be subject to a penalty of up to $1,264 for each failure. Each enrollee who should receive an SBC, but does not, is considered a separate "failure." In

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addition, there is a $100 per participant per day excise tax under Internal Revenue Code section 4980D, which applies except in the case of governmental plans.

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Additional Information

Here are links to additional resources:

DOL Website

SBC templates, instruction, Uniform Glossary, and sample completed SBC:
https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits

CMS Website

Guidance, Fact Sheets, Etc.: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/IndexSummaryBenefitsCoverage.html

SBC templates, instruction, Uniform Glossary, and sample completed SBC:
https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/index.html

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