Health care reform at-a-glance
FAQs: Summary of Benefits and Coverage – Group Business Only

The Affordable Care Act (health care reform law) requires health insurers with fully insured plans and the plan administrator/plan sponsor with ASO plans to provide consumers with an easy-to-understand Summary of Benefits and Coverage (SBC).

We know you have a lot of questions – not just about the law’s requirements – but how we will work together to comply with the health care reform law. This is a huge undertaking and we will need to collaborate to succeed.

The following FAQs are designed to answer some of your questions about the SBC requirement. Please be assured we are working diligently to develop and provide you with comprehensive information about how we will be handling such an important piece of health care reform. So, watch your email in box for more details in the next few weeks. As new guidance is issued, and as necessary, we will update these FAQs. Thank you for your patience as we continue to evaluate and act on the guidance we receive.

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SBC preparation
Q. What does an SBC look like?
A. Please see this pdf for a sample SBC.

Q. For fully insured groups, how will you support the preparation and distribution of SBCs?
A. For fully insured groups, we will prepare and distribute the SBC to the plan administrator. Employers will need to distribute the SBC to their employees, since they are better able to electronically deliver the SBC in a legally compliant fashion to their employees and dependents.

Q. For ASO groups, how will you support the preparation and distribution of SBCs?
A. Both the regulations and the FAQs placed responsibility for creating and distributing SBCs on the ASO plan sponsor/plan administrator. We will work with our ASO groups to develop the SBC for the benefits we provide.

Q. How much notice does Anthem Blue Cross need to create the SBCs prior to renewal?
A. National Account clients – We will need your final decision about your renewing benefits no later than 60 days in advance of the start of your open enrollment period in order to help you provide timely and accurate SBCs to your employees.

Local group clients (any size group) – The HCR SBC regulations specify deadlines for certain scenarios by which SBCs must be delivered to groups and members. Below is a summary of those deadlines. Please work directly with your sales representative to finalize your renewal benefits so these deadlines can be met. Understand that depending on how many
plans you offer your employees <<large group only: and whether you will offer a standard or customized plan>> it may take a week or longer for us to provide you with your final SBCs.

- If your benefits will renew automatically and no application or paperwork is required, your employees must receive a finalized SBC no later than 30 days prior to your renewal date. (SBCs regulations apply beginning on the first day of the first plan year on and after 9/23/12.) For example, if your renewal is 1/1/2013, employees must receive an SBC by 12/1/2012.
- If you will hold an open enrollment period during which your employees may enroll in or change their benefit plan, your employees must receive finalized SBCs with the rest of their open enrollment materials, but no later than the first day of the open enrollment period. (SBCs are required only if the open enrollment period begins on or after 9/23/12.)

Q. Is it required to follow the SBC templates provided by the NAIC?
A. Yes. The templates posted on the CMS website are for use in the first year – on or after September 23, 2012. The agencies anticipate changing the templates for 2014.

Q. What if the plan information does not fit within the provided template?
A. The SBC instructions indicate that if a plan's terms can't be described in a manner consistent with the SBC and the instructions, the plan or issuer should use “best efforts” to describe the plan in a manner that is as consistent with the instructions as reasonably possible.

Q. Is it required to include premium information in the SBC?
A. No, this requirement was removed in the guidance issued February 9, 2012.

Q. The latest updates state that the Coverage Examples were reduced from three to two. What are the required Coverage Examples?
A. The examples are a normal delivery of a baby and well-managed type 2 diabetes. They omitted the breast cancer example.

Q. Which terms will have standard definitions?
A. See Appendix E in the templates and instructions document to see the proposed language and format for the glossary.

Q. Could the templates or required definitions change later?
A. Yes. HHS will periodically review and update the standards for these coverage summaries and definitions. For example, the coverage examples can be changed, and the regulations allow for up to six examples.

Q. What if a state already has standards for benefit summaries?
A. The federal standards will override any state standards that call for less information. But any state mandates that go above and beyond the federal standards will continue to apply.

Q. If an account has multiple carriers with the exact same benefits, is it possible to change the language in the SBC to be consistent with other carriers?
A. SBC language is dictated by HHS for the most part, but the current form allows for some customization of language depending on the field and restrictions in the regulations.

Q. Where can I find the Coverage Examples Calculator?
A. You can find the Coverage Examples Calculator here.
**Coverage Tiers**

**Q.** If an account has cost shares based on coverage tier (i.e., Employee Only / Employee + one / Family), but the benefits are the same, would only 1 SBC still be produced?

**A.** Our SBC tool can generally accommodate two coverage tiers. If an employer has different benefits by coverage tier, we recommend having separate SBCs so the information is clear to the participant.

**Q.** How will SBCs be provided – one SBC per benefit package or one SBC per coverage tier (i.e., Employee Only / Employee + one / Family)?

**A.** As long as benefits do not differ between tiers, a separate SBC is not required for each tier. Our solution for standard plans will default to “Individual / Family” as other coverage tiers like “Individual + Spouse” often have the same deductible and benefits as “Family.” If an employer has different benefits by coverage tier, then we recommend having separate SBCs so the information is clear to the participant.

**SBC delivery**

**Q.** When does the SBC need to be provided?

**A.** The plan issuer (e.g., the plan administrator/plan sponsor with ASO plans, and the insurer with fully insured plans) must provide the SBCs to all groups (small group, large group and National Accounts):

- Within seven business days of a request or application.
- Upon application, if the SBC has changed from the prior version given to the group.
- By the first day of coverage, if the SBC has changed from the version previously given to the group (i.e., at application).
- As part of enrollment materials. However, if the plan does not provide written or electronic enrollment materials as part of the initial enrollment process, the plan must provide the SBC no later than the first day on which the individual is eligible to enroll.
- As part of renewal materials, if the plan or issuer either:
  1. Requires participants and beneficiaries to actively elect to maintain coverage during an open enrollment period, or
  2. Provides them with the opportunity to change coverage options in an open enrollment period.

  The plan or issuer must provide the SBC at the same time it distributes open enrollment materials.

- If there is (1) no requirement to renew (sometimes referred to as an “evergreen” election), and (2) no opportunity to change coverage options, renewal is considered to be “automatic” and the SBC must be provided no later than 30 days prior to the first day of the new plan year.

  In the context of insured coverage, where the renewal is considered to be “automatic,” if the policy has not been issued or renewed before this 30-day period, the SBC must be provided as soon as practicable, but no later than seven business days after the earlier of (1) the issuance of the new policy, or (2) the receipt of written confirmation of the intent to renew.

- Upon a material modification during the policy period (i.e., not at renewal). The notice of material modification can be either an updated SBC or a separate communication that identifies the change(s). The notice should go to the participant. As well, the plan or issuer has an obligation to provide a notice to a beneficiary (i.e. a dependent) where the plan or issuer knows the beneficiary lives at a different address than the participant (please see another FAQ on this topic below). As with the SBC, the employer is responsible for distributing the notice of material modification to participants/beneficiaries.
  - Threshold standard for a material modification:
Before a notice of a material modification must be issued, the material modification must (1) meet the definition of a material modification under ERISA, (2) impact/change the information on the most recently distributed SBC, and (3) be an off-renewal change.

The ERISA definition of a material modification states that it's generally any modification, standing alone or together with other modifications, that an average plan participant would consider to be an important change.

A material modification includes either an enhancement or reduction in services/coverages.

Q. **Can the SBC be combined with other materials?**
A. For groups, the SBC can be combined with other materials (such as the Summary Plan Description) if the SBC is in the **front of the document.** In the individual policy context, the SBC must be provided as a standalone document (i.e., it cannot be combined into a single document with other documents), but it can be included in the same mailing with other documents.

Q. **Which SBC needs to be distributed to group enrollees at the time of initial enrollment as well as on renewal?**
A. As part of the initial enrollment materials, separate SBCs must be provided for each benefit package that the participants/beneficiaries are eligible for. At renewal, participants and beneficiaries are only entitled to the SBC related to the product in which they are enrolled.

At renewal, if participants request an SBC for a plan they are not presently enrolled in, but for which they are eligible, the plan or issuer must provide them that SBC within seven business days of the request.

Q. **What are the requirements for providing an SBC to a dependent in a group?**
A. It must be sent to at the last known address.
   - Plans and insurers do not have to survey members to verify dependent addresses.
   - If the plan or insurer **knows** a dependent lives at another address, the SBC needs to be sent to that address. If the plan knows of another address and does not share this information, both the employer and insurer are liable for not meeting the SBC delivery requirement.
   - If the plan and insurer **do not know** that a dependent lives at another address, we can assume the dependent lives with the subscriber.
   - Under HIPAA, insurers cannot send member information back to employers.

Q. **Does a hard copy of the SBC have to be provided on request?**
A. Yes. ASO group members will be referred back to their group administrator to obtain a copy of the plan SBC (as the group administrator may have customized and/or included carved out benefits in the SBC). We will provide an SBC to a fully insured member who contacts us for one.

Q. **Can the SBC be sent electronically?**
A. From the insurer to a fully insured plan:
   - The SBC may be delivered electronically if:
     - The format is readily accessible by the group.
     - The SBC is provided in a paper form free of charge on request.
     - The electronic form is a website; and the insurer advises the group in paper form or email that the documents are on the Internet and provides the Internet address.

To a participant/beneficiary under **a group health plan subject to ERISA:**
   - To the extent the plan sponsor uses online enrollment or online renewal of coverage for participants/beneficiaries, SBCs may be provided electronically to those participants and beneficiaries. SBCs may also be provided electronically to participants/beneficiaries who request an SBC online.
If the plan sponsor doesn’t offer online enrollment, then the following requirements must be met for the plan sponsor to legally deliver the SBC in an electronic format:

- If a participant/beneficiary is already covered, electronic delivery rules mirror the requirements of the DOL’s electronic disclosure safe harbor regulations (29 CFR Section 2520.104b-1(c)). Under these regulations, paper delivery is probably the best option if the delivery responsibility is not delegated to the group health plan.
- If a participant/beneficiary is eligible but not enrolled, the SBC may be provided electronically if:
  - The format is readily accessible.
  - The SBC is provided in paper form free of charge on request.
  - The electronic form is an Internet posting; and the insurer or group health plan:
    - Timely notifies the pre-enrollee in paper form (such as a postcard) or email that the documents are available on the Internet.
    - Provides the Internet address to the pre-enrollee.
    - Notifies the pre-enrollee that the documents are available in paper form on request.

To a participant/beneficiary under a non-federal government health plans, such as state or local government plans:

- SBCs can be delivered electronically if either (1) the DOL’s electronic disclosure safe harbor requirements (29CFR Section 2520.104b-1(c)) are met, or (2) the rules relating to the electronic delivery of SBCs to individual policyholders are satisfied.
  - To satisfy the electronic SBC delivery requirements for a person that has an individual policy of insurance, a carrier must:
    - Provide the SBC by e-mail after obtaining the individual’s or dependent’s agreement to receive the SBC or other electronic disclosures by e-mail; or
    - Post the SBC on the Internet and advise the individual or dependent in paper or electronic form that the SBC is available on the Internet and include the applicable Internet address.
    - Also, an SBC may not be provided electronically unless:
      (1) The format is readily accessible.
      (2) The SBC is placed in a location that is prominent and readily accessible.
      (3) The SBC is provided in an electronic form which can be electronically retained and printed.
      (4) The SBC is consistent with the appearance, content and language requirements of this section.
      (5) The insurer notifies the individual or dependent that the SBC is available in paper form without charge and provides it on request.

Q. When is a postcard/member email or the Web sufficient for electronic delivery of SBCs?
A. Under group policies, the postcard/email approach can be used for pre-enrollees if the group does not currently have business with us or the enrollee is eligible but not currently enrolled. The postcard/email will direct group “shoppers” to an internet posting where applicable SBC(s) can be viewed. Finally, the postcard/email approach can be used for issuing SBCs to participants and beneficiaries under group non-federal government plans (i.e., state and local government group plans) when an SBC is distributed if the requirements immediately above are followed.

**Timing**

Q. When can I expect to see an SBC for my group?
A. Please work with your Sales/Account representative.

Q. Will you be in compliance with the SBC requirement by September 23, 2012?
A. We are working diligently to meet this deadline.
Q. What happens if an issuer or plan is not in compliance by September 23, 2012?
A. There is a fine of up to $1,000 per consumer where the issuer or plan willfully fails to provide the SBC. In addition, the SBC regulations explicitly authorize the state department of insurance to impose fines in accordance with that state’s regulatory framework. If the state fails to act, then HHS or the DOL can step in and issue a fine of $100 per day per affected individual (this fine is in addition to the fine referenced above for willful conduct) until the SBCs are properly issued.

For example, with a 500-member group, if the plan or issuer willfully fails to provide the SBCs for 30 days (and the state regulator fails to act), the fine could amount to $2 million.

Q. What are the effective dates related to SBCs?
A. The SBC rules have two different effective dates depending on whether the individual is enrolling or re-enrolling during an annual open enrollment period or at a time outside the annual open enrollment period. With respect to participants and beneficiaries enrolling or re-enrolling during an annual enrollment period, the SBC rules are effective on the first day of the first annual enrollment period beginning on and after September 23, 2012.

For all other participants and beneficiaries enrolling other than during an annual enrollment period (e.g., newly eligible individuals and special enrollees), the SBC rules are effective with any enrollment occurring on or after the first day of the plan year that begins on or after September 23, 2012.

For enrollments occurring during an annual open enrollment period, the SBC rule applies to the plan’s first annual enrollment period based on the date that the annual enrollment period begins – not the date the plan year starts. The following examples and table below may be helpful:

Example #1: ABC sponsors a health plan that has a calendar plan year with January 1 being the first day of the plan year. Each year, its open enrollment period begins October 1. ABC must comply with the SBC rules with respect to individuals enrolling or re-enrolling in the annual enrollment period that begins on October 1, 2012 (and each annual open enrollment period thereafter). The SBC rules will also apply to all initial and special enrollments that occur on and after the start of its plan year (i.e., on and after January 1, 2013). Members would only receive SBCs with 2013 benefit information.

Example #2: XYZ sponsors a health plan that has a calendar-year benefit period with January 1 being the first day of the plan year. However, unlike ABC, XYZ typically begins annual enrollment for the following plan year on September 1 of each year. For XYZ, the first annual enrollment period to which the SBC rule will apply is the annual enrollment period beginning September 1, 2013 at which time, members would receive SBCs with 2014 benefit information.

Example #3: MNO has a plan year that runs from March 1 to February 28, with an open enrollment period from January 1 – January 31, 2013, so members enrolling or re-enrolling during the January open enrollment period will get their 2013 plan year SBCs during the January open enrollment period. For any newly eligible and special enrollees, the SBC requirements apply beginning on the first day of the plan year occurring on or after September 23, 2012 (i.e. on and after March 1, 2013). We would not be required to provide 2012 SBCs to the group members, but we would be required to provide it to the group upon request.

Regardless of the group’s open enrollment date, on and after September 23, 2012, the SBC must be provided within seven business days of a request by an employer.

Q. What if benefit changes are requested between the time the SBC is issued (e.g., open enrollment) and the date the benefit /plan year resets? Is this considered a material modification that requires 60 days advance notice to plan enrollees?
A. This is not a material modification. The material modification rules only apply to changes made at a time other than renewal or the new plan year and this change is being requested in advance of the renewal/plan year and will take effect on renewal or start of plan year.
Regulations require that the updated SBC must be provided by the new renewal/plan year date. If a group wants to make changes during this period, we will accommodate their request and provide a revised SBC within 7 business days of receiving the request.

The group administrator is responsible for distributing the revised SBC to plan participants.

Q. **How will special enrollments be handled?**
A. Special enrollment is when a dependent needs to be added to a member’s group plan. For example, this can happen if a spouse loses coverage due to ending employment or termination of their plan.

In this situation, ERISA rules should be followed and the SBC must be sent within 90 days after enrollment. Other examples of special enrollment include eligibility changes due to death, marriage, birth of a dependent, etc. The SBC rules for special enrollees apply beginning on the first day of the first plan year beginning on or after 9/23/12 (i.e., for a 1/1/13 calendar-year plan).
### Scenarios for delivering SBCs to members

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Is member entitled to an SBC during OE in 2012?</th>
<th>When is SBC distributed?</th>
<th>Which plan year benefits are on the SBC?</th>
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<tbody>
<tr>
<td><strong>Enrollment/re-enrollment during open enrollment (for groups)</strong></td>
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<tr>
<td><strong>Group</strong> has open enrollment (OE) <strong>starting 10/1/12</strong>, and the plan is actively marketed.</td>
<td>Yes.</td>
<td>During the plan’s OE period or whenever OE materials are distributed by the employer, any member enrolling or re-enrolling during this OE period receives an SBC for the 2013 plan year.</td>
<td>2013</td>
</tr>
<tr>
<td><strong>Group</strong> has OE <strong>starting 9/1/12</strong>, and the plan is actively marketed.</td>
<td>No.</td>
<td>During the plan’s first OE period after 9/23/12. This would be 9/1/13 for this group.</td>
<td>2014</td>
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<td><strong>Enrollment other than during open enrollment (for groups)</strong></td>
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<tr>
<td><strong>Group</strong> has OE from 9/1/12 to 9/30/12 with a calendar-year plan that begins 1/1/13, and the plan is actively marketed. A new enrollee joins the plan effective 10/1/12.</td>
<td>No.</td>
<td>Enrollees are entitled to SBCs as follows:</td>
<td>2013</td>
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<td>- Starting on the first day of the plan year after 9/23/12.</td>
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<td>- This would be 1/1/13 for this group.</td>
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<td>- A new enrollee that enrolls prior to 1/1/13 would not be entitled to an SBC.</td>
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<td>- If the employer distributes application materials for enrollment, a new enrollee joining on and after 1/1/13 would be entitled to an SBC with the application materials.</td>
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<td>- If the employer does not distribute application materials, the SBC must be provided no later than the first date on which the participant is eligible to enroll.</td>
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<td>- Special enrollees joining the plan on and after 1/1/13 would be entitled to an SBC within 90 days of their enrollment.</td>
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<tr>
<td><strong>Group</strong> has OE from 10/1/12 to 10/31/12 with a calendar-year plan that begins 1/1/13. A new enrollee joins the plan effective 11/5/12.</td>
<td>No.</td>
<td>Enrollees are entitled to SBCs as follows:</td>
<td>2013</td>
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<td>- Starting on the first day of the plan year after 9/23/12.</td>
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<td>- This would be 1/1/13 for this group.</td>
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<td>- Special enrollees joining the plan on and after 1/1/13 would be entitled to an SBC within 90 days of their enrollment.</td>
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<td><strong>Upon request (for groups)</strong></td>
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<td>On or after 9/23/12, a plan administrator requests an SBC.</td>
<td>Yes.</td>
<td>The SBC must be provided within seven business days after receiving the request.</td>
<td>2012 or 2013</td>
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<td><strong>SBC Changes between time of Application and Effective Date</strong></td>
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<td>If there are <strong>changes</strong> in the SBC that was distributed when an enrollee applied for coverage, the plan must update the SBC and provide a current SBC.</td>
<td>No.</td>
<td>The revised SBC must be provided no later than the first day of coverage.</td>
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Applicability of regulations

Q. Is it required by law to provide an SBC to employees?
A. Yes, the Affordable Care Act, also known as the health care reform law, requires that SBCs be provided to all group and individual members.

Q. Must SBCs be provided for insurance products that are no longer being offered for purchase?
A. SBC regulations state that SBCs do not need to be provided for “closed” plans until September 23, 2013. This exception applies to fully-insured plans only. It does not apply to either ASO plans or custom plans.

Closed plans are plans or products that we are no longer selling (not actively marketing). More specifically:

- A “closed” plan is one that is not available to be purchased by a group.
- Groups that are currently on a closed plan may continue to offer the plan as an enrollment option to existing or new employees. The plan is still considered a closed plan because it is not currently marketed. The fact that employees within that group can still enroll in that plan does not change the fact that we will not sell that plan to another group. It is still “closed” by definition, and SBCs do not need to be provided until 9/23/2013.

Q. Does the SBC requirement apply to all plans or just plans offered through insurance exchanges?
A. The requirement applies to all group and individual plans, whether offered through an exchange or outside of the exchange. It also applies to both fully insured and self-insured plans. Finally, it applies to both grandfathered and non-grandfathered plans.

Q. Are plans and issuers required to provide SBCs to individuals who are COBRA-qualified beneficiaries?
A. Yes. While a qualifying event does not, in itself, trigger an SBC, during an open enrollment period, any COBRA-qualified beneficiary who is receiving COBRA coverage must be given the same rights to elect different coverage that are provided to similarly situated non-COBRA beneficiaries. For more information, see FAQ #8 published March 19, 2012 by HHS/DOL/Treasury.

Consumer-Driven Health Plans

Q. For health reimbursement account (HRA) plans, will the HRA allocation be listed on the SBC?
A. Yes. At the top of page 1 of the SBC (see partial snapshot below), we will state: “Employer Health Account Contribution $<contribution amount>. This verbiage will be triggered to be included on the SBC based on the plan type selected and appropriate fields populated.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Q. Will the HRA allocation be included in of the deductible amount?
A. Yes. For example, if the deductible is $1500 and the HRA allocation is $750, the deductible field will list $1500.
**ASO and carve-outs**

**Q.** Can a self-funded account request to do its own SBC? If so, will they be required to sign a form indicating this?

**A.** Yes, however, we will need documentation in writing that the ASO group will be producing their own SBC. Because of provisions in the law, we will need a record of the SBC the group creates. We will also need to monitor their compliance regarding the form’s accuracy and dates of distribution. We will need the ASO group to send a final copy of the SBC to their account representative.

**Q.** Who is responsible for creating the SBC for ASO groups?

**A.** Both the regulations and the FAQs placed responsibility for creating and distributing SBCs on the ASO plan sponsor/plan administrator.

**Q.** Can a group with carve-out benefits provide separate, partial SBCs to members?

**A.** In FAQs released on May 11, 2012, HHS recognized the administrative complexities of creating one SBC when one or more benefits are carved out to multiple carriers and indicated that the development and distribution of multiple, partial SBCs (which together provide all the information required to meet the SBC content requirements) would be allowed. However, groups in this situation, should indicate in a cover letter or note to eligible employees that the plan provides coverage using multiple insurers and that the plan administrator could provide more information on how they all work together.

**Translation**

**Q.** Will you translate SBCs?

**A.** We are committed to meeting the SBC foreign language translation requirement that goes into effect on September 23, 2012. Similar to the Adverse Benefit Determination requirement that went into effect on January 1, 2012, we intend to offer foreign language assistance outside of the 10% threshold counties for the four mandated languages. This will include expanded language options to ensure compliance with all applicable state mandates (i.e., CA SB853). The federal agencies will translate the SBC template, sample language and the uniform glossary in Spanish, Tagalog, Chinese (traditional) and Navajo.

**Q.** How do you determine if the account falls in the 10% county rule?

**A.** HHS provides the information based on census data. For our implementation efforts, we will provide translations regardless of the 10% threshold level.

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