under age 26 who are described in section 152(f)(1) . For an individual not described in section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for dependent child health coverage, such as a condition that the individual be a dependent for income tax purposes.

(c) *Coverage of grandchildren not required.* Nothing in this section requires a plan or issuer to make coverage available for the child of a child receiving dependent coverage.

(d) *Uniformity irrespective of age.* The terms of the plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older).

(e) *Examples.* The rules of paragraph (d) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not attained age 26. The plan imposes an additional premium surcharge for children who are older than age 18.

(ii) *Conclusion.* In this *Example 1,* the plan violates the requirement of paragraph (d) of this section because the plan varies the terms for dependent coverage of children based on age.

Example 2. (i) *Facts.* A group health plan offers a choice among the following tiers of health coverage: Self-only, self-plus-one, self-plus-two, and self-plus-three-or-more. The cost of coverage increases based on the number of covered individuals. The plan provides dependent coverage of children who have not attained age 26.

(ii) *Conclusion.* In this *Example 2,* the plan does not violate the requirement of paragraph (d) of this section that the terms of dependent coverage for children not vary based on age. Although the cost of coverage increases for tiers with more covered individuals, the increase applies without regard to the age of any child.

Example 3. (i) *Facts.* A group health plan offers two benefit packages—an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not attained age 26. The plan limits children who are older than age 18 to the HMO option.

(ii) *Conclusion.* In this *Example 3,* the plan violates the requirement of paragraph (d) of this section because the plan, by limiting children who are older than age 18 to the HMO option, varies the terms for dependent coverage of children based on age.

Example 4. (i) *Facts.* A group health plan sponsored by a large employer normally charges a copayment for physician visits that do not constitute preventive services. The plan charges this copayment to individuals age 19 and over, including employees, spouses, and dependent children, but waives it for those under age 19.

(ii) *Conclusion.* In this *Example 4,* the plan does not violate the requirement of paragraph (d) of this section that the terms of dependent coverage for children not vary based on age. While the requirement of paragraph (d) of this section generally prohibits distinctions based upon age in dependent coverage of children, it does not prohibit distinctions based upon age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children. In this *Example 4,* the copayments charged to dependent children are the same as those charged to employees and spouses. Accordingly, the arrangement described in this *Example 4* (including waiver, for individuals under age 19, of the generally applicable copayment) does not violate the requirement of paragraph (d) of this section.

(f) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

[T.D. 9744, 80 FR 72245, Nov. 18, 2015]

§54.9815–2715 Summary of benefits and coverage and uniform glossary.

(a) *Summary of benefits and coverage—*(1) *In general.* A group health plan (and its administrator as defined in section 3(16)(A) of ERISA)), and a health insurance issuer offering group health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

(i) *SBC provided by a group health insurance issuer to a group health plan—*(A) *Upon application.* A health insurance issuer offering group health insurance coverage must provide the SBC to

a group health plan (or its sponsor) upon application for health coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. If an SBC was provided before application pursuant to paragraph (a)(1)(i)(D) of this section (relating to SBCs upon request), this paragraph (a)(1)(i)(A) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information required, a new SBC that includes the changed information must be provided upon application pursuant to this paragraph (a)(1)(i)(A).

(B) *By first day of coverage (if there are changes).* If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the issuer must update and provide a current SBC to the plan (or its sponsor) no later than the first day of coverage.

(C) *Upon renewal, reissuance, or re-enrollment.* If the issuer renews or reissues a policy, certificate, or contract of insurance for a succeeding policy year, or automatically re-enrolls the policyholder or its participants and beneficiaries in coverage, the issuer must provide a new SBC as follows:

(*1*) If written application is required (in either paper or electronic form) for renewal or reissuance, the SBC must be provided no later than the date the written application materials are distributed.

(*2*) If renewal, reissuance, or reenrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, 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 in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(D) *Upon request.* If a group health plan (or its sponsor) requests an SBC or summary information about a health insurance product from a health insurance issuer offering group health insurance coverage, an SBC must be provided as soon as practicable, but in no event later than seven business days following receipt of the request.

(ii) *SBC provided by a group health insurance issuer and a group health plan to participants and beneficiaries*—(A) *In general.* A group health plan (including its administrator, as defined under section 3(16) of ERISA), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary (as defined under sections 3(7) and 3(8) of ERISA), and consistent with the rules of paragraph (a)(1)(iii) of this section, with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.

(B) *Upon application.* The SBC must be provided as part of any written application materials that are distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute written application materials for enrollment, the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage for the participant or any beneficiaries. If an SBC was provided before application pursuant to paragraph (a)(1)(ii)(F) of this section (relating to SBCs upon request), this paragraph (a)(1)(ii)(B) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information that is required to be in the SBC, a new SBC that includes the changed information must be provided upon application pursuant to this paragraph (a)(1)(ii)(B).

(C) *By first day of coverage (if there are changes).* (*1*) If there is any change to the information required to be in the SBC that was provided upon application and before the first day of coverage, the plan or issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

(*2*) If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, the plan or issuer is not required to provide an updated SBC (unless an updated SBC is

requested) until the first day of coverage.

(D) *Special enrollees.* The plan or issuer must provide the SBC to special enrollees (as described in §54.9801–6) no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is 90 days from enrollment.

(E) *Upon renewal, reissuance, or re-enrollment.* If the plan or issuer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), or automatically re-enrolls participants and beneficiaries in coverage, the plan or issuer must provide a new SBC, as follows:

(*1*) If written application is required for renewal, reissuance, or reenrollment (in either paper or electronic form), the SBC must be provided no later than the date on which the written application materials are distributed.

(*2*) If renewal, reissuance, or reenrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, 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 in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(F) *Upon request.* A plan or issuer must provide the SBC to participants or beneficiaries upon request for an SBC or summary information about the health coverage, as soon as practicable, but in no event later than seven business days following receipt of the request.

(iii) *Special rules to prevent unnecessary duplication with respect to group health coverage*—(A) An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with the other rules of this section. Therefore, for example, in the case of a group health plan funded through an insurance policy, the plan satisfies the requirement to provide an SBC with respect to an individual if the issuer provides a timely and complete SBC to the individual. An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual that contracts with another party to provide such SBC is considered to satisfy the requirement to provide such SBC if:

(*1*) The entity monitors performance under the contract;

(*2*) If the entity has knowledge that the SBC is not being provided in a manner that satisfies the requirements of this section and the entity has all information necessary to correct the noncompliance, the entity corrects the noncompliance as soon as practicable; and

(*3*) If the entity has knowledge the SBC is not being provided in a manner that satisfies the requirements of this section and the entity does not have all information necessary to correct the noncompliance, the entity communicates with participants and beneficiaries who are affected by the noncompliance regarding the noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

(B) If a single SBC is provided to a participant and any beneficiaries at the participant's last known address, then the requirement to provide the SBC to the participant and any beneficiaries is generally satisfied. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

(C) With respect to a group health plan that offers multiple benefit packages, the plan or issuer is required to provide a new SBC automatically to participants and beneficiaries upon renewal or reenrollment only with respect to the benefit package in which a participant or beneficiary is enrolled (or will be automatically re-enrolled under the plan); SBCs are not required to be provided automatically upon renewal or reenrollment with respect to

benefit packages in which the participant or beneficiary is not enrolled (or will not automatically be enrolled). However, if a participant or beneficiary requests an SBC with respect to another benefit package (or more than one other benefit package) for which the participant or beneficiary is eligible, the SBC (or SBCs, in the case of a request for SBCs relating to more than one benefit package) must be provided upon request as soon as practicable, but in no event later than seven business days following receipt of the request.

(D) Subject to paragraph (a)(2)(ii) of this section, a plan administrator of a group health plan that uses two or more insurance products provided by separate health insurance issuers with respect to a single group health plan may synthesize the information into a single SBC or provide multiple partial SBCs provided that all the SBC include the content in paragraph (a)(2)(iii) of this section.

(2) *Content*—(i) *In general.* Subject to paragraph (a)(2)(iii) of this section, the SBC must include the following:

(A) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage, in accordance with guidance as specified by the Secretary;

(B) A description of the coverage, including cost sharing, for each category of benefits identified by the Secretary in guidance;

(C) The exceptions, reductions, and limitations of the coverage;

(D) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;

(E) The renewability and continuation of coverage provisions;

(F) Coverage examples, in accordance with the rules of paragraph (a)(2)(ii) of this section;

(G) With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;

(H) 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;

(I) Contact information for questions;

(J) For issuers, an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained;

(K) 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;

(L) 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; and

(M) An Internet address for obtaining the uniform glossary, as described in paragraph (c) of this section, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

(ii) *Coverage examples.* The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions) in accordance with this paragraph (a)(2)(ii).

(A) *Number of examples.* The Secretary may identify up to six coverage examples that may be required in an SBC.

(B) *Benefits scenarios.* For purposes of this paragraph (a)(2)(ii), a benefits scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality. The Secretary will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

(C) *Illustration of benefit provided.* For purposes of this paragraph (a)(2)(ii), to illustrate benefits provided under the plan or coverage for a particular benefits scenario, a plan or issuer simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the plan, policy, or benefit package. The illustration of benefits provided will take into account any cost sharing, excluded benefits, and other limitations on coverage, as specified by the Secretary in guidance.

(iii) *Coverage provided outside the United States.* In lieu of summarizing coverage for items and services provided outside the United States, a plan or issuer may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. In any case, the plan or issuer must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the plan or coverage within the United States.

(3) *Appearance.* (i) A group health plan and a health insurance issuer must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than 12-point font.

(ii) A group health plan that utilizes two or more benefit packages (such as major medical coverage and a health flexible spending arrangement) may synthesize the information into a single SBC, or provide multiple SBCs.

(4) *Form.* (i) An SBC provided by an issuer offering group health insurance coverage to a plan (or its sponsor), may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the following three conditions are satisfied—

(A) The format is readily accessible by the plan (or its sponsor);

(B) The SBC is provided in paper form free of charge upon request; and

(C) If the electronic form is an Internet posting, the issuer timely advises the plan (or its sponsor) in paper form or email that the documents are available on the Internet and provides the Internet address.

(ii) An SBC provided by a group health plan or health insurance issuer to a participant or beneficiary may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the requirements of this paragraph (a)(4)(ii) are met.

(A) With respect to participants and beneficiaries covered under the plan or coverage, the SBC may be provided electronically as described in this paragraph (a)(4)(ii)(A). However, in all cases, the plan or issuer must provide the SBC in paper form if paper form is requested.

(*1*) In accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b–1;

(*2*) In connection with online enrollment or online renewal of coverage under the plan; or

(*3*) In response to an online request made by a participant or beneficiary for the SBC.

(B) With respect to participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if:

(*1*) The format is readily accessible;

(*2*) The SBC is provided in paper form free of charge upon request; and

(*3*) In a case in which the electronic form is an Internet posting, the plan or issuer timely notifies the individual in paper form (such as a postcard) or email that the documents are available on the Internet, provides the Internet address, and notifies the individual that the documents are available in paper form upon request.

(5) *Language.* A group health plan or health insurance issuer must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this paragraph (a)(5), a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 29 CFR 2590.715–2719(e) are met as applied to the SBC.

(b) *Notice of modification.* If a group health plan, or health insurance issuer

offering group health insurance coverage, makes any material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective. The notice of modification must be provided in a form that is consistent with the rules of paragraph (a)(4) of this section.

(c) *Uniform glossary*—(1) *In general.* A group health plan, and a health insurance issuer offering group health insurance coverage, must make available to participants and beneficiaries the uniform glossary described in paragraph (c)(2) of this section in accordance with the appearance and form and manner requirements of paragraphs (c)(3) and (4) of this section.

(2) *Health-coverage-related terms and medical terms.* The uniform glossary must provide uniform definitions, specified by the Secretary in guidance, of the following health-coverage-related terms and medical terms:

(i) Allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network co-insurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and

(ii) Such other terms as the Secretary determines are important to define so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits), as specified in guidance.

(3) *Appearance.* A group health plan, and a health insurance issuer, must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee.

(4) *Form and manner.* A plan or issuer must make the uniform glossary described in this paragraph (c) available upon request, in either paper or electronic form (as requested), within seven business days after receipt of the request.

(d) *Preemption.* State laws that conflict with this section (including a state law that requires a health insurance issuer to provide an SBC that supplies less information than required under paragraph (a) of this section) are preempted.

(e) *Failure to provide.* A group health plan that willfully fails to provide information required under this section to a participant or beneficiary is subject to a fine of not more than $1,000 for each such failure. A failure with respect to each participant or beneficiary constitutes a separate offense for purposes of this paragraph (e). The Department will enforce this section using a process and procedure consistent with section 4980D of the Code.

(f) *Applicability to Medicare Advantage benefits.* The requirements of this section do not apply to a group health plan benefit package that provides Medicare Advantage benefits pursuant to or 42 U.S.C. Chapter 7, Subchapter XVIII, Part C.

(g) *Applicability date.* (1) This section is applicable to group health plans and group health insurance issuers in accordance with this paragraph (g). (See 29 CFR 2590.715–1251(d), providing that this section applies to grandfathered health plans.)

(i) For disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including re-enrollees and late enrollees), this section applies beginning on the first day of the first

open enrollment period that begins on or after September 1, 2015; and

(ii) For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), this section applies beginning on the first day of the first plan year that begins on or after September 1, 2015.

(2) For disclosures with respect to plans, this section is applicable to health insurance issuers beginning September 1, 2015.

[T.D. 9724, 80 FR 34304, June 16, 2015]

§ 54.9815–2715A1 Transparency in coverage—definitions.

(a) *Scope and definitions*—(1) *Scope.* This section sets forth definitions for the price transparency requirements for group health plans and health insurance issuers offering group health insurance coverage established in this section and §§ 54.9815–2715A2 and 54.9815–2715A3.

(2) *Definitions.* For purposes of this section and §§ 54.9815–2715A2 and 54.9815–2715A3, the following definitions apply:

(i) *Accumulated amounts* means:

(A) The amount of financial responsibility a participant or beneficiary has incurred at the time a request for cost-sharing information is made, with respect to a deductible or out-of-pocket limit. If an individual is enrolled in other than self-only coverage, these accumulated amounts shall include the financial responsibility a participant or beneficiary has incurred toward meeting his or her individual deductible or out-of-pocket limit, as well as the amount of financial responsibility that all the individuals enrolled under the plan or coverage have incurred, in aggregate, toward meeting the other than self-only deductible or out-of-pocket limit, as applicable. Accumulated amounts include any expense that counts toward a deductible or out-of-pocket limit (such as a copayment or coinsurance), but exclude any expense that does not count toward a deductible or out-of-pocket limit (such as any premium payment, out-of-pocket expense for out-of-network services, or amount for items or services not covered under the group health plan or health insurance coverage); and

(B) To the extent a group health plan or health insurance issuer imposes a cumulative treatment limitation on a particular covered item or service (such as a limit on the number of items, days, units, visits, or hours covered in a defined time period) independent of individual medical necessity determinations, the amount that has accrued toward the limit on the item or service (such as the number of items, days, units, visits, or hours the participant or beneficiary, has used within that time period).

(ii) *Beneficiary* has the meaning given the term under section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA).

(iii) *Billed charge* means the total charges for an item or service billed to a group health plan or health insurance issuer by a provider.

(iv) *Billing code* means the code used by a group health plan or health insurance issuer or provider to identify health care items or services for purposes of billing, adjudicating, and paying claims for a covered item or service, including the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis-Related Group (DRG) code, National Drug Code (NDC), or other common payer identifier.

(v) *Bundled payment arrangement* means a payment model under which a provider is paid a single payment for all covered items and services provided to a participant or beneficiary for a specific treatment or procedure.

(vi) *Copayment assistance* means the financial assistance a participant or beneficiary receives from a prescription drug or medical supply manufacturer towards the purchase of a covered item or service.

(vii) *Cost-sharing liability* means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost-sharing liability generally includes deductibles, coinsurance, and copayments, but does not include premiums, balance billing amounts by out-of-network providers,