

(iii) *Example.* The following example illustrates the application of this paragraph (d)(3):

Example. (i) *Facts.* Husband (H), a U.S. citizen, dies in 2011 having made no taxable gifts during his lifetime. H's gross estate is \$3,000,000. H's wife (W) is not a citizen of the United States and, under H's will, a pecuniary bequest of \$2,000,000 passes to a QDOT for the benefit of W. H's executor timely files an estate tax return and makes the QDOT election for the property passing to the QDOT, and H's estate is allowed a marital deduction of \$2,000,000 under section 2056(d) for the value of that property. H's taxable estate is \$1,000,000. On H's estate tax return, H's executor computes H's preliminary DSUE amount to be \$4,000,000. No taxable events within the meaning of section 2056A occur during W's lifetime with respect to the QDOT, and W resides in the United States at all times after H's death. W makes a taxable gift of \$1,000,000 to X in 2012 and a taxable gift of \$1,000,000 to Y in January 2015, in each case from W's own assets rather than from the QDOT. W dies in September 2015, not having married again, when the value of the assets of the QDOT is \$2,200,000.

(ii) *Application.* H's DSUE amount is redetermined to be \$1,800,000 (the lesser of the \$5,000,000 basic exclusion amount for 2011, or the excess of H's \$5,000,000 applicable exclusion amount over \$3,200,000 (the sum of the \$1,000,000 taxable estate augmented by the \$2,200,000 of QDOT assets)). On W's gift tax return filed for 2012, W cannot apply any DSUE amount to the gift made to X. However, because W's gift to Y was made in the year that W died, W's executor will apply \$1,000,000 of H's redetermined DSUE amount to the gift on W's gift tax return filed for 2015. The remaining \$800,000 of H's redetermined DSUE amount is included in W's applicable exclusion amount to be used in computing W's estate tax liability.

(e) *Authority to examine returns of deceased spouses.* For the purpose of determining the DSUE amount to be included in the applicable exclusion amount of a surviving spouse, the Internal Revenue Service (IRS) may examine returns of each of the surviving spouse's deceased spouses whose DSUE amount is claimed to be included in the surviving spouse's applicable exclusion amount, regardless of whether the period of limitations on assessment has expired for any such return. The IRS's authority to examine returns of a deceased spouse applies with respect to each transfer by the surviving spouse to which a DSUE amount is or has been applied. Upon examination, the IRS may adjust or eliminate the DSUE amount reported on such a return of a deceased spouse; however, the IRS may assess additional tax on that return only if that tax is assessed within the period of limitations on assessment under section 6501 applicable to the tax

shown on that return. See also section 7602 for the IRS's authority, when ascertaining the correctness of any return, to examine any returns that may be relevant or material to such inquiry.

(f) *Availability of DSUE amount for nonresidents who are not citizens.* A nonresident surviving spouse who was not a citizen of the United States at the time of making a transfer subject to tax under chapter 12 of the Internal Revenue Code shall not take into account the DSUE amount of any deceased spouse except to the extent allowed under any applicable treaty obligation of the United States. See section 2102(b)(3).

(g) *Effective/applicability date.* This section applies to gifts made on or after June 12, 2015. See 26 CFR 25.2505-2T, as contained in 26 CFR part 25, revised as of April 1, 2015, for the rules applicable to gifts made on or after January 1, 2011, and before June 12, 2015.

§ 25.2505-2T [Removed]

■ **Par. 18.** Section 25.2505-2T is removed.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

■ **Par. 19.** The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

■ **Par. 20.** In § 602.101, paragraph (b) is amended by:

- 1. Removing the entry for 20.2010-2T.
- 2. Adding in numerical order an entry for 20.2010-2.

The addition reads as follows:

§ 602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR Part or section where identified and described	Current OMB control No.
* * * * *	* * * * *
20.2010-2	1545-0015
* * * * *	* * * * *

John M. Dalrymple,
Deputy Commissioner for Services and Enforcement.

Approved: June 8, 2015.

Mark J. Mazur,
Assistant Secretary of Treasury (Tax Policy).
[FR Doc. 2015-14663 Filed 6-12-15; 4:15 pm]

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[TD-9724]

RIN 1545-BM53

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210-AB69

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 147

[CMS-9938-F]

RIN 0938-AS54

Summary of Benefits and Coverage and Uniform Glossary

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final rules.

SUMMARY: This document contains final regulations regarding the summary of benefits and coverage (SBC) and the uniform glossary for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act. It finalizes changes to the regulations that implement the disclosure requirements under section 2715 of the Public Health Service Act to help plans and individuals better understand their health coverage, as well as to gain a better understanding of other coverage options for comparison.

DATES: *Effective Date:* These final regulations are effective on August 17, 2015.

FOR FURTHER INFORMATION CONTACT: Elizabeth Schumacher or Amber Rivers, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317-5500; Heather Raeburn, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (301) 492-4224.

Customer Service Information: Individuals interested in obtaining

information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's Web site (<http://www.dol.gov/ebsa>). In addition, information from HHS on private health insurance for consumers can be found on CMS's Web site (www.cms.gov/ccio) and information on health reform can be found at <http://www.healthcare.gov>.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act, Public Law 111-152, was enacted on March 30, 2010. These statutes are collectively known as the Affordable Care Act. The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.¹ The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by this reference are sections 2701 through 2728.

Section 2715 of the PHS Act, as added by the Affordable Care Act, directs the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments)² to develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage in compiling and providing a summary of benefits and coverage (SBC) that "accurately describes the benefits and coverage under the applicable plan or coverage." PHS Act section 2715 also calls for the "development of standards

for the definitions of terms used in health insurance coverage."

In accordance with the statute, the Departments, in developing such standards, consulted with the National Association of Insurance Commissioners (referred to in this document as the "NAIC"),³ and the NAIC provided its final recommendations to the Departments regarding the SBC on July 29, 2011. On August 22, 2011, the Departments published proposed regulations (2011 proposed regulations) and an accompanying document soliciting comments on the template, instructions, and related materials for implementing the disclosure provisions under PHS Act section 2715.⁴ After consideration of all the comments received on the 2011 proposed regulations and accompanying documents, the Departments published joint final regulations to implement the disclosure requirements under PHS Act section 2715 on February 14, 2012 (2012 final regulations) and an accompanying document with the template, instructions, and related materials.⁵

After the 2012 final regulations were published, the Departments released Frequently Asked Questions (FAQs) regarding implementation of the SBC provisions as part of six issuances. The Departments released FAQs about Affordable Care Act Implementation Parts VII, VIII, IX, X, XIV, and XIX to answer outstanding questions, including questions related to the SBC.⁶ These

³ The NAIC convened a working group (NAIC working group) comprised of a diverse group of stakeholders. This working group met frequently for over one year while developing its recommendations. In developing its recommendations, the NAIC considered the results of various consumer testing sponsored by both insurance industry and consumer associations. Throughout the process, NAIC working group draft documents and meeting notes were displayed on the NAIC's Web site for public review, and several interested parties filed formal comments. In addition to participation from the NAIC working group members, conference calls and in-person meetings were open to other interested parties and individuals and provided an opportunity for non-member feedback. See www.naic.org/committees_b_consumer_information.htm.

⁴ See proposed regulations, published at 76 FR 52442 (August 22, 2011) and guidance document published at 76 FR 52475 (August 22, 2011).

⁵ See final regulations, published at 77 FR 8668 (February 14, 2012) and guidance document published at 77 FR 8706 (February 14, 2012).

⁶ See Frequently Asked Questions about Affordable Care Act Implementation Part VII (available at www.dol.gov/ebsa/faqs/faq-aca7.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html); Part VIII (available at www.dol.gov/ebsa/faqs/faq-aca8.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html); Part IX (available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html); Part X

FAQs addressed questions related to compliance with the requirements of the 2012 final regulations, implemented additional safe harbors,⁷ and released updated SBC materials.

On December 30, 2014, the Departments issued proposed regulations (December 2014 proposed regulations), as well as a new proposed SBC template, instructions, an updated uniform glossary, and other materials to incorporate some of the feedback the Departments have received and to make some improvements to the template.⁸ The draft updated template, instructions, and supplementary materials are available at <http://www.cms.gov/ccio> and <http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html>.

On March 30, 2015, the Departments released an FAQ stating that the Departments intend to finalize changes to the regulations in the near future but intend to utilize consumer testing and offer an opportunity for the public, including the NAIC, to provide further input before finalizing revisions to the SBC template and associated documents.⁹ The Departments anticipate the new template and associated documents will be finalized by January 2016 and will apply to coverage that would renew or begin on the first day of the first plan year (or, in the individual market, policy year) that begins on or after January 1, 2017 (including open season periods that occur in the Fall of 2016 for coverage beginning on or after January 1, 2017).

After consideration of the comments and feedback received from stakeholders in response to the December 2014 proposed regulations, the Departments are publishing these final regulations. In response to the 2014 proposed regulations, the Departments received comments on the regulations as well as the template and

(available at www.dol.gov/ebsa/faqs/faq-aca10.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs10.html); Part XIV (available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html); and Part XIX (available at www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html).

⁷ As discussed more fully herein, some of the enforcement safe harbors and transitions are being made permanent (several with modifications) by these final regulations.

⁸ See proposed regulations published at 79 FR 78577 (December 30, 2014).

⁹ See Frequently Asked Questions about Affordable Care Act Implementation Part XXIV, available at <http://www.dol.gov/ebsa/faqs/faq-aca24.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs24.html.

¹ The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan," as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insured group health plans.

² Note, however, that in sections under headings listing only two of the three Departments, the term "Departments" generally refers only to the two Departments listed in the heading.

associated documents. The Departments received many comments on the proposed changes to the template and associated documents but received very few comments relating to the regulations. As stated in the FAQ issued on March 30, 2015, the Departments anticipate the new template and associated documents will be finalized by January 2016, and, therefore, only the comments on the regulations will be addressed in this final rule. Comments relating to the template and associated documents will be addressed when those documents are finalized.

II. Overview of the Final Regulations

A. Requirement To Provide a Summary of Benefits and Coverage

1. Provision of the SBC by an Issuer to a Plan

Under paragraph (a)(1)(i) of the 2012 final regulations, a health insurance issuer offering group health insurance coverage must provide an SBC to a group health plan (or its sponsor) upon an application by the plan for health coverage. The issuer must provide the SBC as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. The Departments proposed to add language to clarify that, under the 2012 final regulations, a health insurance issuer offering group health insurance coverage (or plan, if applicable, under paragraph (a)(1)(ii), as discussed below) is not required to automatically provide the SBC again if the issuer already provided the SBC before application to any entity or individual, provided there is no change in the information required to be in the SBC.

The comments the Departments received on this clarification generally supported the proposed language and, accordingly, these final regulations finalize the language of the proposed regulations without change. Therefore, these final regulations include language clarifying that, if the issuer provides the SBC upon request before application for coverage, the requirement to provide an SBC upon application is deemed satisfied, and the issuer is not required to automatically provide another SBC upon application to the same entity or individual, 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 to be included in the SBC, a new SBC that includes the changed information must be provided upon application (that is, as soon as practicable following receipt of the application, but in no event later

than seven business days following receipt of the application).

Under paragraph (a)(i)(B) of the 2012 final regulations, 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. If the information is unchanged, the issuer does not need to provide the SBC again in connection with coverage for that plan year, except upon request. The December 2014 proposed regulations stated that if the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, an updated SBC is not required to be provided to the plan or its sponsor (unless an updated SBC is requested) until the first day of coverage. The updated SBC should reflect the final coverage terms under the policy, certificate, or contract of insurance that was purchased.

Some commenters supported the clarification and stated that if there is a change in the information required, a new SBC that includes the changed information must be provided upon application. Other commenters stated that enrollees in both the group and individual markets need to know of pending plan changes during open and special enrollment periods so that they can make informed decisions about their plan options.

These final regulations finalize the language of the proposed regulations without change. Therefore, if the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, an updated SBC is not required to be provided to the plan or its sponsor (unless an updated SBC is requested) until the first day of coverage. The updated SBC is required to reflect the final coverage terms under the policy, certificate, or contract of insurance that was purchased.

2. Provision of the SBC by a Plan or Issuer to Participants and Beneficiaries

Under paragraph (a)(1)(ii) of 2012 final regulations, a group health plan (including the plan administrator), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary¹⁰

¹⁰ ERISA section 3(7) defines a participant as: any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employers or members of such organization, or

with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.¹¹ The December 2014 proposed regulations clarified that if the plan or issuer provides the SBC prior to application for coverage, the plan or issuer is not required to automatically provide another SBC upon application, if there is no change to the information required to be in the SBC. If there is any change to the information required to be in the SBC by the time the application is filed, the plan or issuer must update and provide a current SBC as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

The comments the Departments received on this proposal generally supported adopting the language of the proposed regulations, which incorporates this clarification of the 2012 final regulations. Therefore, these final regulations provide that if an SBC was provided upon request before application, the requirement to provide the SBC upon application 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 to be in the SBC, a new SBC that includes the updated information must be provided as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

Under the 2012 final regulations, 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. The December 2014 proposed regulations addressed how to satisfy the requirement to provide an SBC when the terms of coverage are not finalized.

whose beneficiaries may be eligible to receive any such benefit. ERISA section 3(8) defines a beneficiary as: a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

¹¹ With respect to insured group health plan coverage, PHS Act section 2715 generally places the obligation to provide an SBC on both the group health plan and health insurance issuer. As discussed below, under section III.A.1.d., "Special Rules to Prevent Unnecessary Duplication with Respect to Group Health Coverage", if either the issuer or the plan provides the SBC, both will have satisfied their obligations. As they do with other notices required of both plans and issuers under part 7 of ERISA, title XXVII of the PHS Act, and Chapter 100 of the Code, the Departments expect plans and issuers to make contractual arrangements for sending SBCs. Accordingly, the remainder of this preamble generally refers to requirements for plans or issuers.

Those proposed regulations proposed that 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. The updated SBC would be required to reflect the final coverage terms under the policy, certificate, or contract of insurance that was purchased. The Departments did not receive comments relating to this provision, and, therefore, these final regulations finalize the language of the proposed regulations without change.

Under the 2012 final regulations, the plan or issuer must also provide the SBC to individuals enrolling through a special enrollment period, also called special enrollees.¹² Special enrollees must be provided with an SBC no later than when 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.

The December 2014 proposed regulations followed the approach of the 2012 final rules with respect to this requirement and did not include a proposed change. The proposed regulations provided that, to the extent individuals who are eligible for special enrollment would like to receive SBCs earlier than this timeframe, they may request an SBC with respect to any particular plan, policy, or benefit package and the SBC is required to be provided as soon as practicable, but in no event later than seven business days following receipt of the request. The Departments received several comments relating to the timeframe. While some commenters supported the existing requirement, other commenters stated that the Departments should require plans and issuers to provide the SBC to special enrollees upon enrollment or by the first day of coverage. Some commenters stated that rules should require plans and issuers to treat special enrollees the same as applicants for coverage, which would require provision of the SBC as soon as practicable following receipt of an application, but in no event later than seven business days following receipt of the application.

The Departments recognize the importance of special enrollees having information about a plan, policy, or benefit package for which they are

¹² See special enrollment regulations published at 26 CFR 54.9801-6, 29 CFR 2590.701-6, and 45 CFR 146.117.

eligible; however, special enrollees have the opportunity to obtain this information by requesting the SBC. Accordingly, these regulations retain the provision of the proposed regulations regarding special enrollees without change. To the extent that individuals who are eligible for special enrollment and are contemplating their coverage options would like to receive SBCs earlier, they may always request an SBC with respect to any particular plan, policy, or benefit package, and the SBC is required to be provided as soon as practicable, but in no event later than seven business days following receipt of the request. Therefore, these final regulations continue to provide that the plan or issuer must provide the SBC to individuals enrolling through a special enrollment period, also called special enrollees, no later than when 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.

B. Special Rules To Prevent Unnecessary Duplication With Respect to Group Health Coverage

Paragraph (a)(1)(iii) of the 2012 final regulations sets forth three special rules to streamline provision of the SBC and avoid unnecessary duplication with respect to group health coverage. In addition to retaining these three existing special rules, the Departments proposed adding two additional provisions, and codifying an enforcement safe harbor set forth in a previous FAQ,¹³ to ensure participants and beneficiaries receive information while preventing unnecessary duplication. The first proposed provision sought to address circumstances where an entity required to provide an SBC with respect to an individual has entered into a binding contract with another party to provide the SBC to the individual. In such a case, the proposed regulations stated that the entity would be considered to satisfy the requirement to provide the SBC with respect to the individual if specified conditions are met:

(1) The entity monitors performance under the contract;¹⁴

¹³ See Affordable Care Act Implementation FAQs Part IX, question 10, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

¹⁴ The selection and monitoring of service providers for a group health plan, including parties assuming responsibility to complete, provide information for, or deliver SBCs, is a fiduciary act subject to prudence and loyalty duties and prohibited transaction provisions of ERISA. No single fiduciary procedure will be appropriate in all cases; the procedure for selecting and monitoring

(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.

In response to this proposal, some commenters expressed concern that the proposed approach would permit circumstances where a group health plan that contracts with a third party administrator is deemed compliant with the requirements, although certain participants and beneficiaries under the plan have not received an SBC. On the other hand, the Departments received comments recommending the final regulations eliminate the requirement to monitor the performance of contractors, arguing that it is unnecessary and unduly burdensome.

In light of all the comments received, the Departments finalize the proposed approach without change. The approach set forth by the Departments works to achieve the goals of preventing unnecessary duplication for plans and issuers, while incorporating safeguards to ensure that participants and beneficiaries receive the requisite information. The Departments believe that the requirement to monitor the performance under the contract is necessary to ensure that participants and beneficiaries receive the information to which they are entitled. The Departments may provide additional guidance if the Departments become aware of situations where participants and beneficiaries are not being provided SBCs in accordance with these final regulations.

The second provision proposed by the Departments addressed unnecessary duplication with respect to a group health plan that uses two or more

service providers may vary in accordance with the nature of the plan and other facts and circumstances relevant to the choice of the service provider. More general information on hiring and monitoring service providers is contained in the Department of Labor publication "Understanding Your Fiduciary Responsibilities Under a Group Health Plan," which is available at: www.dol.gov/ebsa/publications/ghpfiduciaryresponsibilities.html.

insurance products provided by separate issuers to insure benefits under the plan. The Departments recognize that a plan sponsor may purchase an insurance product for certain coverage from a particular issuer and purchase a separate insurance product or self-insure with respect to other coverage (such as outpatient prescription drug coverage). In these circumstances, the first issuer may or may not know of the existence of other coverage, or whether the plan sponsor has arranged the two benefit packages as a single plan or two separate plans.

To address these arrangements, the December 2014 proposed regulations proposed that, with respect to a group health plan that uses two or more insurance products provided by separate issuers, the group health plan administrator is responsible for providing complete SBCs with respect to the plan. The group health plan administrator may contract with one of its issuers (or other service providers) to perform that function. Absent a contract to perform the function, an issuer has no obligation to provide coverage information for benefits that it does not insure. The comments the Departments received on this proposed provision generally supported the approach, and therefore these regulations also finalize this rule without change.

To address concerns regarding unnecessary duplication in situations where plans may have benefits provided by more than one issuer, the Departments set forth an enforcement safe harbor in an FAQ on May 11, 2012,¹⁵ which permitted the provision of multiple partial SBCs if certain conditions were satisfied. The Departments extended this enforcement safe harbor for one year on April 23, 2013,¹⁶ and indefinitely on May 2, 2014.¹⁷ The Departments requested comment on whether to codify this policy in the final regulations.

Some commenters supported the policy in the enforcement safe harbor and either requested the Departments extend the enforcement safe harbor or codify it in regulations. Other

commenters requested that the Departments require plan administrators to synthesize the information into a single SBC in order to meet the SBC content requirements when two or more insurance products are provided by separate issuers with respect to a single group health plan.

These final regulations codify this enforcement safe harbor, which permits a group health plan administrator to synthesize the information into a single SBC or provide multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements.

C. Provision of the SBC by an Issuer Offering Individual Market Coverage

Paragraph (a)(1)(iv) of the HHS 2012 final regulations sets forth standards applicable to individual health insurance coverage, under which the provision of the SBC by an issuer offering individual market coverage largely parallels the group market requirements described above, with only those changes necessary to reflect the differences between the two markets. The rules provide that a health insurance issuer offering individual health insurance coverage must provide an SBC to an individual or dependent upon receiving an application for any health insurance policy as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.¹⁸ 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 an individual or dependent no later than the first day of coverage.

The December 2014 proposed regulations proposed to clarify when the issuer must provide the SBC again if the issuer already provided the SBC prior to application. HHS proposed that if the issuer provides the SBC prior to application for coverage, the issuer is not required to automatically provide another SBC upon application, if there is no change to the information required to be in the SBC. If there is any change to the information required to be in the SBC that was provided prior to application for coverage by the time the application is filed, the issuer must update and provide a current SBC to the

same individual or dependent as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

The comments received on this proposal generally supported adopting the language of the proposed regulation. Therefore, these final regulations provide that if an SBC was provided upon request before application, the requirement to provide the SBC upon application 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 as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

HHS also proposed to address situations where an issuer offering individual market insurance coverage, consistent with applicable Federal and State law, automatically reenrolls an individual and any dependents into a different plan or product than the plan in which these individuals were previously enrolled. If the issuer automatically re-enrolls an individual covered under a policy, certificate, or contract of insurance (including every dependent) into a policy, certificate, or contract of insurance under a different plan or product, HHS proposed that the issuer would be required to provide an SBC with respect to the coverage in which the individual (including every dependent) will be enrolled, consistent with the timing requirements that apply when the policy is renewed or reissued. The comments received regarding this proposal supported this proposed approach. Therefore, these final regulations finalize the proposed approach without change.

D. Special Rules To Prevent Unnecessary Duplication With Respect to Individual Health Insurance Coverage

Student health insurance coverage is a type of individual health insurance coverage provided pursuant to a written agreement between an institution of higher education and a health insurance issuer to students enrolled in that institution of higher education, and their dependents, that meet certain specified conditions.¹⁹ The December 2014 proposed regulations proposed to extend an anti-duplication rule similar to that provided with respect to group health coverage to student health

¹⁵ Affordable Care Act Implementation FAQs Part IX, question 10, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

¹⁶ Affordable Care Act Implementation FAQs Part XIV, question 5, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html.

¹⁷ Affordable Care Act FAQ Part XIX, question 8, available at www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html.

¹⁸ We clarify for issuers participating in an Exchange for the individual market, an issuer's obligation to provide the SBC upon "application" is triggered by the issuer's receipt of notice from the Exchange of the individual's plan selection, rather than the Exchange's receipt of the individual's eligibility application.

¹⁹ See 45 CFR 147.145, published at 77 FR 16453 (March 21, 2012).

insurance coverage. HHS proposed that the requirement to provide an SBC with respect to an individual would be considered satisfied for an entity (such as an institution of higher education) if another party (such as a health insurance issuer) provides a timely and complete SBC to the individual. HHS solicited comments on whether or not a requirement to monitor the provisioning of the SBC in this circumstance should be added.

The comments received generally supported this proposal. Most of the commenters supported requiring the entity that is contracting the provisioning of the SBC to a different entity to monitor the contract to ensure individuals receive an SBC. However, a few commenters stated that such a requirement would be unnecessary and unduly burdensome.

Considering the comments received, these final regulations adopt an anti-duplication provision with respect to providing SBCs for student health insurance coverage, with the addition of a duty to monitor that parallels the duty to monitor that is being finalized with respect to the anti-duplication rule for group health plans. HHS believes that the requirement to monitor the performance under the contract is necessary to ensure that individuals receive the information to which they are entitled. HHS may provide additional guidance if the Departments become aware of situations where individuals are not being provided SBCs in accordance with these final regulations.

E. Content

PHS Act section 2715(b)(3) generally provides that the SBC must include nine statutory content elements. The 2012 final regulations added three content elements: (1) for plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of the network providers; (2) 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 under the plan or coverage; and (3) an Internet address for obtaining the uniform glossary, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies of the uniform glossary are available.

1. Minimum Essential Coverage and Minimum Value Statement

One of the statutory content elements is a statement of whether the plan or coverage provides minimum essential coverage (MEC) as defined under section 5000A(f) of the Code, and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage is not less than 60% of those costs. In April 2013, the Departments issued an updated SBC template (and sample completed SBC) with the addition of statements regarding whether the plan or coverage provides MEC (as defined under section 5000A(f) of the Code) and whether the plan or coverage meets the minimum value (MV) requirements.²⁰ In Affordable Care Act Implementation FAQs Part XIV, issued contemporaneously with the updated SBC template in April 2013, the Departments stated that this language is required to be included in SBCs provided with respect to coverage beginning on or after January 1, 2014.²¹

The Departments also stated in Affordable Care Act Implementation FAQs Part XIV that if a plan or issuer was unable to modify the SBC template for these disclosures, the Departments would not take any enforcement action against a plan or issuer for using the original template authorized at the time the 2012 final regulations were issued, provided that the SBC was furnished with a cover letter or similar disclosure stating whether the plan or coverage does or does not provide MEC and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage does or does not meet the MV standard under the Affordable Care Act.²² As

²⁰ See Affordable Care Act Implementation FAQs Part XIV, question 1, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html.

²¹ The guidance with respect to statements regarding MEC and MV was originally issued for SBCs provided with respect to coverage beginning on or after January 1, 2014, and before January 1, 2015 (referred to as the "second year of applicability"). See Affordable Care Act Implementation FAQs Part XIV, question 1, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html. This guidance was extended to be applicable until further guidance was issued. See Affordable Care Act Implementation FAQs Part XIX, question 7, available at www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html.

²² See Affordable Care Act Implementation FAQs Part XIV, question 2, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html.

stated in the FAQ issued on March 30, 2015, the Departments anticipate finalizing the new template and associated documents by January 2016. Therefore, until the new template and associated documents are finalized and applicable, plans and issuers may continue to rely on the flexibility provided in Affordable Care Act Implementation FAQs Part XIV²³ and the Departments will not take enforcement action against a plan or issuer that provides an SBC with a cover letter or similar disclosure with the required MEC and MV statements.²⁴

2. QHP and Abortion Services

Under section 1303(b)(3)(A) of the Affordable Care Act and implementing regulations at 45 CFR 156.280(f), a Qualified Health Plan (QHP) issuer that elects to offer a QHP that provides coverage of abortion services for which federal funding is prohibited (non-excepted abortion services) must provide a notice to enrollees, as part of the SBC provided at the time of enrollment, of coverage of such services.

The December 2014 proposed regulations proposed to require issuers of QHPs sold through an individual market Exchange to disclose on the SBC these QHPs whether abortion services are covered or excluded, and whether coverage is limited to services for which federal funding is allowed (excepted abortion services). Several commenters supported this proposal. Some commenters recommended that the requirement to disclose coverage or exclusion of abortion services be expanded to all plans and issuers offering coverage in all markets, not only issuers of QHPs in the individual market. Finally, some commenters recommended limiting the required disclosure to only a QHP issuer that offers a QHP providing coverage of non-excepted abortion services.

After consideration of all the comments regarding this proposal, these final regulations adopt the proposed approach without change. These final regulations require that QHP issuers must disclose on the SBC for QHPs sold through an individual market Exchange whether abortion services are covered or excluded, and whether coverage is limited to excepted abortion services.

²³ Affordable Care Act Implementation FAQs Part XIV, question 2, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html.

²⁴ HHS also notes that until the new template and associated documents are finalized and applicable, it will not take enforcement action against an individual market issuer for omitting such a statement for minimum value, which is not relevant with respect to individual market coverage.

HHS feels that this level of transparency is important to facilitate comparisons across individual market QHPs, and to avoid confusion regarding which abortion services are or are not covered.

The December 2014 proposed regulations were published contemporaneously with proposed updates to the SBC template, instructions, and associated documents. The proposed updates to the SBC template instructions and associated documents included guidance for QHP issuers regarding the wording and placement of the abortion disclosure requirement on the SBC. We received numerous comments regarding the proposed language for the disclosure, as well as the placement of the disclosure on the SBC template. As previously stated, the Departments anticipate finalizing the new template and associated documents, separately from this final rule, by January 2016. HHS will consider and address the comments regarding the wording and placement of the disclosure in finalizing the new template and associated documents. HHS acknowledges that QHP issuers will not have final guidance regarding the specific wording and placement of this disclosure until the template, instructions, and associated documents are finalized. Therefore, until the new template and associated documents are finalized and applicable, individual market QHP issuers may adopt any reasonable wording and placement of the disclosure on the SBC. Individual market QHP issuers may also provide the disclosure in a cover letter or other similar disclosure provided with the SBC. Consistent with the effective dates described in section K of this final rule, this requirement is applicable for individual market QHP issuers for SBCs issued in connection with coverage that begins on or after January 1, 2016.

For Multi-State Plan issuers, the Office of Personnel Management will issue guidance about the wording and placement of the abortion disclosure requirement on the SBC.

3. Contact Information for Questions

The statute provides that the SBC must include “a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.” The 2012 final regulations state that the SBC must include “contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and an

Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance).” These final regulations clarify that all plans and issuers must include on the SBC contact information for questions.

4. Internet Address To Obtain the Actual Individual Underlying Policy or Group Certificate

Questions have arisen as to whether PHS Act section 2715(b)(3)(i) (which requires that an SBC include “. . . an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained”) and associated regulations require that all plans and issuers must post underlying plan documents automatically on an Internet Web site. Some commenters stated that plans and issuers should be required to post actual policy and underlying plan documents as well as direct links to the plan’s prescription drug formulary. Other commenters stated that the Departments should permit plan sponsors to decide whether the underlying plan documents are posted online. Others stated that mandating self-insured group health plans to post underlying plan information online is redundant and burdensome.

The statutory language regarding this requirement refers specifically to an “individual coverage policy” and “group certificate of coverage.” This statutory provision does not reference group health plan coverage that provides benefits on a self-insured basis. While the Departments recognize that such information may be useful to consumers, based on the statutory language, the Departments may only require issuers to post the underlying individual coverage policy or group certificate of coverage to an Internet address. Accordingly, these final regulations provide that issuers must also include an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. The Departments note that these final regulations require these documents to be easily available to individuals, plan sponsors, and participants and beneficiaries shopping for coverage prior to submitting an application for coverage. For the group market only, because the actual “certificate of coverage” is not available until after the plan sponsor has negotiated the terms of coverage with the issuer, an issuer is permitted to satisfy this requirement with respect to plan sponsors that are shopping for coverage by posting a sample group certificate of coverage for

each applicable product. After the actual certificate of coverage is executed, it must be easily available to plan sponsors and participants and beneficiaries via an Internet web address.

The Departments note that nothing in this section prohibits issuers and group health plan sponsors from making additional underlying group health plan or policy documents more readily available to participants and beneficiaries, including by posting them on the internet. HHS encourages issuers to make all relevant policy documents easily accessible to individuals shopping for, and enrolled in, coverage to facilitate comparison of policy options and understanding of benefits available under a particular plan or policy.

The Departments also note that, separate from the SBC requirement, provisions of other applicable laws require disclosure of plan documents and other instruments governing the plan. For example, ERISA section 104 and the Department of Labor’s implementing regulations²⁵ provide that, for plans subject to ERISA, the plan documents and other instruments under which the plan is established or operated must generally be furnished by the plan administrator to plan participants²⁶ upon request. In addition, the Department of Labor’s claims procedure regulations (applicable to ERISA plans), as well as the Departments’ claims and appeals regulations under the Affordable Care Act (applicable to all non-grandfathered group health plans and health insurance issuers in the group and individual markets),²⁷ set forth rules regarding claims and appeals, including the right of claimants (or their authorized representatives) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided by the plan or issuer, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant’s

²⁵ 29 CFR 2520.104b-1.

²⁶ ERISA section 3(7) defines a “participant” to include any employee or former employee who is or may become eligible to receive a benefit of any type from an employee benefit plan or whose beneficiaries may be eligible to receive any such benefit. Accordingly, employees who are not enrolled but are, for example, in a waiting period for coverage, or who are otherwise shopping amongst benefit package options at open season, generally are considered plan participants for this purpose.

²⁷ 29 CFR 2560.503-1. See also 29 CFR 2590.715-2719(b)(2)(i) and 45 CFR 147.136(b)(2)(i), requiring nongrandfathered plans and issuers to incorporate the internal claims and appeals processes set forth in 29 CFR 2560.503-1.

claim for benefits. Plans and issuers must continue to comply with these provisions and any other applicable laws.

F. Appearance

PHS Act section 2715 sets forth standards related to the appearance and language of the SBC. Specifically, the SBC is to be presented in a culturally and linguistically appropriate manner utilizing terminology understandable by the average plan enrollee, in a uniform format that does not exceed four double-sided pages in length, and does not include print smaller than 12-point font. Plans and issuers have informed the Departments that they are concerned about including all of the required information in the SBC while also satisfying the limitation on the length of the document of four double-sided pages. Comments were invited on potential ways to reconcile the statutory page limit with the statutory content, appearance, and format requirements, particularly the need for the summary to present information in an understandable, accurate, and meaningful way that facilitates comparisons of health options, including those that have disparate and comparatively complex features. Specifically, the Departments invited comments on the sorts of plans that have difficulty meeting the statutory limit, and what other sorts of accommodations may be appropriate for those plans.

Some commenters expressed concern regarding the difficulty of complying with the statutory page limit. One commenter stated that it is difficult to provide customers with clear and accurate information while describing the benefits provided under certain complex plan designs. As discussed above, the statute requires that the SBC not exceed four pages, and these final regulations retain the interpretation set forth in the 2012 final regulations that the SBC can be four double-sided pages. The Departments will address specific issues related to completing the four-page template, as well as the issues plans and issuers encounter meeting these requirements with the finalization of the new template and associated documents, separate from this final rule.

G. Form

1. Group Health Plan Coverage

To facilitate faster and less burdensome disclosure of the SBC and to be consistent with PHS Act section 2715(d)(2), which permits disclosure in either paper or electronic form, the 2012 final regulations set forth rules to permit

greater use of electronic transmittal of the SBC. For SBCs provided electronically by a plan or issuer to participants and beneficiaries, the 2012 final regulations make a distinction between a participant or beneficiary who is already covered under the group health plan and a participant or beneficiary who is eligible for coverage but not enrolled in a group health plan. For participants and beneficiaries who are already covered under the group health plan, the 2012 final regulations permit provision of the SBC electronically, if the requirements of the Department of Labor's regulations at 29 CFR 2520.104b-1 are met. Paragraph (c) of those regulations includes an electronic disclosure safe harbor.²⁸ For participants and beneficiaries who are eligible for but not enrolled in coverage, the 2012 final regulations permit the SBC to be provided electronically, if the format is readily accessible²⁹ and a paper copy is provided free of charge upon request. Additionally, to reduce paper copies that may be unnecessary, if the electronic form is an Internet posting, the plan or issuer must timely advise the individual in paper form (such as a postcard) or email that the documents are available on the Internet, provide the Internet address, and notify the individual that the documents are available in paper form upon request. The Departments note that the rules for participants and beneficiaries who are eligible for but not enrolled in coverage are substantially similar to the requirements for an issuer providing an electronic SBC to a group health plan (or its sponsor) under paragraph (a)(4)(i) of the regulations. Finally, plans, and participants and beneficiaries (both those covered and those eligible but not enrolled), have the right to receive an SBC in paper form, free of charge, upon request.

In Affordable Care Act Implementation FAQs Part IX, question 1, the Departments adopted an additional safe harbor related to

²⁸ On April 7, 2011, the Department of Labor published a Request for Information regarding electronic disclosure at 76 FR 19285. In it, the Department of Labor stated that it is reviewing the use of electronic media by employee benefit plans to furnish information to participants and beneficiaries covered by employee benefit plans subject to ERISA. Because these SBC regulations adopt the ERISA electronic disclosure rules by cross-reference, any changes that may be made to 29 CFR 2520.104b-1 in the future would also apply to the SBC.

²⁹ The Departments note that our use of the phrase "readily accessible" in this context is not intended to connote terms of art, such as "reasonable accommodation," "readily achievable," and "accessible," as used in connection with the determination of legal requirements with regard to disability.

electronic delivery of SBCs.³⁰ In the December 2014 proposed regulations, the Departments proposed to codify this safe harbor through rulemaking. Commenters generally supported permitting electronic delivery of SBCs. Some commenters requested the Departments adopt the safe harbor outlined in the FAQ. Other commenters recommended adopting the safe harbor standard for all individuals receiving the SBC without making any distinction as to whether the individual is already enrolled in the plan.

These final regulations adopt the safe harbor for electronic delivery set forth in the FAQ without expanding the application of the safe harbor to all individuals entitled to receive the SBC. The Departments note that these rules provide a mechanism by which all SBCs may be provided electronically. The Departments believe that the approach set forth in the FAQ achieves an appropriate balance between ensuring participants and beneficiaries receive the necessary information, while allowing plans and issuers to provide such information electronically. Thus, SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs also may be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request.

2. Individual Health Insurance Coverage and Self-insured Non-Federal Governmental Plans

The HHS 2012 final regulations established a provision under paragraph (a)(4)(iii)(C) that deems health insurance issuers in the individual market to be in compliance with the requirement to provide the SBC to an individual requesting summary information about a health insurance product prior to submitting an application for coverage if the issuer provides the content required under paragraph (a)(2) of the regulations to the federal health reform Web portal described in 45 CFR 159.120. Issuers must submit all of the content required under paragraph (a)(2), as specified in guidance by the Secretary, to be deemed compliant with the requirement to provide an SBC to an individual requesting summary information prior to submitting an application for coverage. HHS intends to continue to

³⁰ See Affordable Care Act Implementation FAQs Part IX, question 4, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

facilitate the operation of this deemed compliance option for individual market issuers. An issuer must provide all SBCs other than the “shopper” SBC contemplated in the deemed compliance provision as required under the 2012 final regulations (and any future final regulations), including providing the SBC at the time of application and renewal.

The Departments note that, consistent with the 2012 final regulations, an issuer in the individual market must provide the SBC in a manner that can reasonably be expected to provide actual notice regardless of the format. An issuer in the individual market satisfies the form requirements set forth in the 2012 final regulations if it does at least one of the following: (1) Hand-delivers a paper copy of the SBC to the individual or dependent; (2) mails a paper copy of the SBC to the mailing address provided to the issuer by the individual or dependent; (3) provides the SBC by email after obtaining the individual's or dependent's agreement to receive the SBC or other electronic disclosures by email; (4) posts the SBC on the Internet and advises the individual or dependent in paper or electronic form, in a manner compliant with 45 CFR 147.200(a)(4)(iii)(A)(1) through (3), that the SBC is available on the Internet and includes the applicable Internet address; or (5) provides the SBC by any other method that can reasonably be expected to provide actual notice.

The 2012 final regulations also provide that the obligation to provide an SBC cannot be satisfied electronically in the individual market unless: The format is readily accessible; the SBC is displayed in a location that is prominent and readily accessible; the SBC is provided in an electronic form that can be electronically retained and printed; the SBC is consistent with the appearance, content, and language requirements; and the issuer notifies the individual that a paper SBC is available upon request without charge.³¹

The December 2014 proposed regulations proposed to clarify the form and manner for SBCs provided by a self-insured non-Federal governmental plan. Under the proposal, such SBCs could be provided in paper form. Alternatively, such SBCs could be provided electronically if the plan conforms to either the substance of the provisions applicable to ERISA plans (in paragraph (a)(4)(ii) of the regulations) or to

individual health insurance coverage (in paragraph (a)(4)(iii) of the regulations).

The Departments did not receive any comments regarding this proposal. Therefore, the Departments are finalizing the proposal without change, to allow for self-insured non-Federal governmental plans to provide an SBC in either paper form, or electronically if the plan conforms to either the substance of the provisions applicable to ERISA plans (in paragraph (a)(4)(ii) of the regulations) or to individual health insurance coverage (in paragraph (a)(4)(iii) of the regulations).

H. Language

PHS Act section 2715(b)(2) provides that standards shall ensure that the SBC “is presented in a culturally and linguistically appropriate manner.” The 2012 final regulations provide that a plan or issuer for this purpose is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 45 CFR 147.136(e), implementing standards for the form and manner of notices related to internal claims appeals and external review, are met as applied to the SBC.³²

To help plans and issuers meet the language requirements of paragraph (a)(5) of the 2012 final regulations, as requested by commenters, HHS provided written translations of the SBC template, sample language, and the uniform glossary in Chinese, Navajo, Spanish, and Tagalog (the four languages with populations meeting the thresholds outlined in 45 CFR 147.136(e)).³³ HHS may also make these materials available in other languages to facilitate voluntary distribution of SBCs to other individuals with limited English proficiency. The Departments requested comment on this standard, and on other potential standards that could facilitate consistency across the Departments' programs.

Some commenters requested an additional standard that would require the translation of the SBC into any language spoken by 500 individuals or 5 percent of individuals in the plan's service area or an employer's workforce, whichever is less, and to include taglines in at least 15 languages on all SBCs that indicate the availability of translated SBCs and oral language

services. Some commenters were concerned that the 10 percent standard for language and translation services is insufficient to present the SBC in a culturally and linguistically appropriate manner and cited different Federal standards for other disclosures. Other commenters supported the existing requirement from the 2012 final regulations or stated that the prevalence of speakers of a language in a particular state is the best criteria for identifying which language services should be provided.

The Departments believe that it is important to provide SBCs in a culturally and linguistically appropriate manner to ensure that individuals get the important information needed to properly evaluate coverage options. The standard established under the 2012 final regulations addresses the need to provide language services to ensure that consumers receive SBCs in an understandable format while balancing that need with the goal of keeping administrative costs down. Additionally, a rule based on a particular number or percentage of a plan's population, rather than a county's population, may increase administrative costs and make it difficult for plans and issuers to provide SBCs that comply with the page limitations. Therefore, these final rules continue to provide that a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 45 CFR 147.136(e), implementing standards for the form and manner of notices related to internal claims appeals and external review, are met as applied to the SBC.^{34 35}

I. Process for Imposition of Fine in the Case of Willful Violation

In general, PHS Act section 2715(f) provides that a group health plan (including its administrator), and a health insurance issuer offering group or individual health insurance coverage, that willfully fails to provide the information required under this section are subject to a fine. In the December 2014 proposed regulations, the Department of Labor proposed that it will use the same process and

³⁴ See 75 FR 43330 (July 23, 2010), as amended by 76 FR 37208 (June 24, 2011).

³⁵ Nothing in these regulations should be construed as limiting an individual's rights under other Federal authorities applicable to recipients of Federal financial assistance, such as Section 504 of the Rehabilitation Act of 1973, which includes effective communication requirements for individuals with disabilities, and Title VI of the Civil Rights Act of 1964, which includes language assistance requirements for individuals with limited English proficiency.

³¹ We clarify that an issuer's posting of the SBC on its Web site is not sufficient by itself; paragraph (a)(4)(iii) of the 2012 final regulations requires the SBC to be provided in a manner that can reasonably be expected to provide actual notice in paper or electronic form.

³² See 75 FR 43330 (July 23, 2010), as amended by 76 FR 37208 (June 24, 2011). Guidance on the HHS Web site contains a list of the counties that meet this threshold. This information is available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data-12-05-14_clean_508.pdf.

³³ Translations are available at <http://ccio.cms.gov/programs/consumer/summaryandglossary/index.html>.

procedures for assessment of the civil fine as used for failure to file an annual report under 29 CFR 2560.502c-2 and 29 CFR part 2570, subpart C. In accordance with ERISA section 502(b)(3), 29 U.S.C. 1132(b)(3), the Secretary of Labor is not authorized to assess this fine against a health insurance issuer. Moreover, the IRS proposed to clarify that the IRS will enforce this section using a process and procedure consistent with section 4980D of the Code. The Departments did not receive comments on this proposal to utilize existing processes and procedures under ERISA and the Code and therefore finalize these proposals without change.

J. Applicability

In August 2012, the Departments issued FAQs³⁶ that provided a temporary nonenforcement policy with respect to group health plans providing Medicare Advantage benefits, which are Medicare benefits financed by the Medicare Trust Funds, for which the benefits are set by Congress and regulated by the Centers for Medicare & Medicaid Services. The December 2014 proposed regulations proposed to add language to codify this temporary relief and exempt from the SBC requirements a group health plan benefit package that provides Medicare Advantage benefits. Medicare Advantage benefits are not health insurance coverage, and Medicare Advantage organizations are not required to provide an SBC with respect to such benefits. Additionally, there are separately required disclosures required to be provided by Medicare Advantage organizations to ensure that enrollees in these plans receive the necessary information about their coverage and benefits.

The Departments did not receive comments opposing the proposal to exempt group health plans providing Medicare Advantage benefits from the SBC requirements. Therefore, these final regulations finalize without change the proposal to codify the relief and exempt from the SBC requirements a group health plan benefit package that provides Medicare Advantage benefits.

In May 2012, the Departments issued FAQs addressing insurance products that are no longer being offered for purchase (“closed blocks of business”). The Departments had provided temporary enforcement relief through an FAQ provided that certain conditions were met: (1) The insurance product is

no longer being actively marketed; (2) the health insurance issuer stopped actively marketing the product prior to September 23, 2012, when the requirement to provide an SBC was first applicable to health insurance issuers; and (3) the health insurance issuer has never provided an SBC with respect to such product.³⁷ The Departments reiterated that relief in the December 2014 proposed regulations, and we do so again in these final regulations. But, we again note that if an insurance product was actively marketed for business on or after September 23, 2012, and is no longer being actively marketed for business, or if the plan or issuer ever provided an SBC in connection with the product, the plan and issuer must provide the SBC with respect to such coverage, as required by PHS Act section 2715 and these final regulations.

K. Applicability Date

The December 2014 proposed regulations proposed that these rules, if finalized, would apply for disclosures with respect to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees) beginning on the first day of the first open enrollment period that begins on or after September 1, 2015. With respect to disclosures to participants and beneficiaries who enroll in group health coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the requirements were proposed to apply beginning on the first day of the first plan year that begins on or after September 1, 2015. For disclosures to plans, and to individuals and dependents in the individual market, these requirements were proposed to apply to health insurance issuers beginning on September 1, 2015. Comments received generally supported these applicability dates, except that a number of commenters suggested that the requirements apply with respect to the individual market for coverage beginning on or after January 1, 2016. These final regulations adopt the applicability dates as proposed, except that for disclosures to individuals and dependents in the individual market, the requirements apply to health insurance issuers with respect to SBCs issued for coverage that begins on or after January 1, 2016. Until these final

regulations become applicable, plans and issuers must continue to comply with the 2012 final regulations, as applicable.

III. Economic Impact and Paperwork Burden

A. Executive Orders 12866 and 13563—Departments of Labor and HHS

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated a “significant regulatory action” under section 3(f) of Executive Order 12866. Accordingly, the rule has been reviewed by the Office of Management and Budget.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year). As discussed below, the Departments have concluded that these final regulations would not have economic impacts of \$100 million or more in any one year or otherwise meet the definition of an “economically significant rule” under Executive Order 12866. Nonetheless, consistent with Executive Orders 12866 and 13563, the Departments have provided an assessment of the potential benefits and the costs associated with these final regulations.

These final regulations are expected to have only small benefits and costs as they primarily provide clarifications of the previous 2012 final regulations and also incorporate into regulations previous guidance issued by the Departments that has taken the form of responses to frequently asked questions or enforcement safe harbors.³⁸ The Departments have not been able to quantify these costs and benefits, but they are qualitatively discussed below.

The clarifications would help lower costs as they establish that duplicate SBCs do not have to be provided upon application if a previous SBC was provided and there have been no changes to the required information. The clarification also prevents

³⁶ See Affordable Care Act Implementation FAQs Part X, question 1, available at <http://www.dol.gov/ebsa/faqs/faq-aca10.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs10.html.

³⁷ See Affordable Care Act Implementation FAQs Part IX, question 12, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

³⁸ See Affordable Care Act Implementation FAQs Part XXIV available at <http://www.dol.gov/ebsa/faqs/faq-aca24.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs24.html.

unnecessary duplications for plans and issuers, while incorporating safeguards to ensure that participants and beneficiaries (and covered individuals and dependents) receive the required information. These final regulations also provide flexibility in providing SBCs for the situation where a plan has multiple issuers and also adopt the safe harbor for electronic delivery previously set forth in an FAQ, thereby reducing the cost of delivery.

These final regulations also require an issuer to provide an internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. The costs associated with this requirement are discussed in the Paperwork Reduction Act section below.

B. Paperwork Reduction Act

1. Departments of Labor and the Treasury

These final rules are not subject to the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), because these final regulations make no changes to the existing collection of information as defined in 44 U.S.C. 3502(3).

Please note that the proposed regulations included an ICR related to the revision of the SBC template that has been omitted in these final regulations as the Departments intend to utilize consumer testing and offer an opportunity for public comment before finalizing revisions to the SBC template. An analysis under the PRA will be conducted when the SBC template is finalized.

2. Department of Health and Human Services

These final regulations require health insurance issuers offering group and individual health insurance coverage must include in the SBC an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. These documents are required to be easily available to individuals, plan sponsors, and participants and beneficiaries shopping for coverage prior to submitting an application for coverage. With respect to group health coverage, because the actual "certificate of coverage" is not available until after the plan sponsor has negotiated the terms of coverage with the issuer, an issuer is permitted to satisfy this requirement with respect to plan sponsors that are shopping for coverage by posting a sample group certificate of coverage for each

applicable product. After the actual certificate of coverage is executed, it must be easily available to plan sponsors and participants and beneficiaries via an Internet web address.

Some commenters stated that requiring the individual coverage policy documents and group certificates of coverage be made available by posting to an Internet web address would be unduly burdensome because of the requirement to make the documents available to individuals and plan sponsors shopping for coverage, but not yet enrolled in coverage. The December 2014 proposed regulations estimated the burden for this requirement to be de minimis because the documents already exist and issuers already have web addresses where the materials can be made available. Additionally, HHS understands that issuers already frequently make these materials available online to individuals, plan sponsors, and participants and beneficiaries after enrollment in coverage. These final regulations clarify that these documents must be made available online to those shopping for coverage prior to enrollment as well. It is not expected that group health insurance issuers will be providing access to group certificates of coverage prior to execution of the final group certificate of coverage. Instead, HHS anticipates and expects that the sample group certificate of coverage that underlies the product being marketed and sold, and that have been filed with and approved by a state Department of Insurance, are what will be provided prior to the execution of the actual group certificate of coverage. Based on this HHS still believes that the requirement to make these documents available via an Internet web address will result in only a de minimis burden on issuers.

These final regulations make no other revisions to the existing collection of information. The December 2014 proposed regulations included an ICR related to the revision of the SBC template that has been omitted in these final regulations as the Departments intend to utilize consumer testing and offer an opportunity for public comment before finalizing revisions to the SBC template. An analysis under the PRA will be conducted when the SBC template is finalized.

The Department notes that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number.

The 2015–2017 paperwork burden estimates are summarized as follows:
Type of Review: Revision.

Agency: Department of Health and Human Services.

Title: Summary of Benefits and Coverage Uniform Glossary

CMS Identifier (OMB Control Number): CMS–10407 (0938–1146).

Affected Public: Private sector.

Total Respondents: 126,500.

Total Responses: 41,153,858.

Frequency of Response: On-going.

Estimated Total Annual Burden Hours (three year average): 322,411 hours.

Estimated Total Annual Cost Burden (three year average): \$7,207,361.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and which are likely to have a significant economic impact on a substantial number of small entities. Unless the head of an agency certifies that a proposed rule is not likely to have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires that the agency present an initial regulatory flexibility analysis (IRFA) describing the rule's impact on small entities and explaining how the agency made its decisions with respect to the application of the rule to small entities.

The RFA generally defines a "small entity" as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 *et seq.*), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. (States and individuals are not included in the definition of "small entity.")

There are several different types of small entities affected by these final regulations. For issuers and third party administrators, the Departments use as their measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent. For plans, the Departments continue to consider a small plan to be an employee benefit plan with fewer than 100 participants.³⁹

³⁹The basis for this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans that cover fewer than 100 participants.

Further, while some large employers may have small plans, in general small employers maintain most small plans. Thus, the Departments believe that assessing the impact of this final rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 *et seq.*).

The Departments carefully considered the likely impact of these final rules on small entities in connection with their assessment under Executive Order 12866. The incremental changes of these final regulations impose minimal additional costs, but also serve to reduce the costs of compliance by providing help to plans and service providers by providing clarifications. These final regulations also incorporate into regulations previous guidance from the Departments that has taken the form of responses to frequently asked questions or enforcement safe harbors. Accordingly, pursuant to section 605(b) of the RFA, the Departments hereby certify that these final regulations will not have a significant economic impact on a substantial number of small entities.

D. Unfunded Mandates Reform Act—Department of Labor and Department of Health and Human Services

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any final rule that includes a Federal mandate that could result in expenditure in any one year by State, local or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars updated annually for inflation. In 2015, that threshold level is approximately \$144 million. These final regulations include no mandates on State, local, or Tribal governments. These final regulations propose requirements regarding standardized consumer disclosures that would affect private sector firms (for example, health insurance issuers offering coverage in the individual and group markets, and third-party administrators providing administrative services to group health plans), but we conclude that these costs would not exceed the \$144 million threshold. Thus, the Departments of Labor and HHS conclude that these final regulations would not impose an unfunded mandate on State, local or

Tribal governments or the private sector. Regardless, consistent with policy embodied in UMRA, the final requirements described in this notice of final rulemaking has been designed to be the least burdensome alternative for State, local and Tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

E. Federalism Statement—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have “substantial direct effects” on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have federalism implications must consult with State and local officials and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments of Labor’s and HHS’ view, these final regulations have federalism implications because they would have direct effects on the States, the relationship between the national government and the States, or on the distribution of power and responsibilities among various levels of government relating to the disclosure of health insurance coverage information to consumers. Under these final regulations, all group health plans and health insurance issuers offering group or individual health insurance coverage, including self-funded non-federal governmental plans as defined in section 2791 of the PHS Act, would be required to follow uniform standards for compiling and providing a summary of benefits and coverage to consumers. Such Federal standards developed under PHS Act section 2715(a) would preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under PHS Act section 2715(a).

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of

section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the requirements in title XXVII of the PHS Act (including those added by the Affordable Care Act) are not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of a Federal standard. The conference report accompanying HIPAA indicates that this is intended to be the “narrowest” preemption of State laws (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018).

States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law. However, under these final rules, a State would not be allowed to impose a requirement that modifies the summary of benefits and coverage required to be provided under PHS Act section 2715(a), because it would prevent the application of these final rules’ uniform disclosure requirements.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments of Labor and HHS have engaged in efforts to consult with and work cooperatively with affected States, including consulting with, and attending conferences of, the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis. It is expected that the Departments of Labor and HHS will act in a similar fashion in enforcing the Affordable Care Act, including the provisions of section 2715 of the PHS Act. Throughout the process of developing these final regulations, to the extent feasible within the applicable preemption provisions, the Departments of Labor and HHS have attempted to balance the States’ interests in regulating health insurance issuers, and Congress’ intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments of Labor’s and HHS’ view

that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this final rule, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached final rules in a meaningful and timely manner.

F. Special Analyses—Department of the Treasury

For purposes of the Department of the Treasury it has been determined that this notice of final rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these final regulations. For a discussion of the impact of this final rule on small entities, please see section V.C. of this preamble. Pursuant to section 7805(f) of the Code, this notice of final rulemaking has been submitted to the Small Business Administration for comment on its impact on small business.

G. Congressional Review Act

These final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

IV. Statutory Authority

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law 104–191, 110 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Public Law 111–148, 124 Stat. 119, as amended by

Public Law 111–152, 124 Stat. 1029; Secretary of Labor's Order 1–2011, 77 FR 1088 (January 9, 2012).

The Department of Health and Human Services regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, State regulation of health insurance.

Dated: June 8, 2015.

John Dalrymple,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: June 9, 2015.

Mark J. Mazur,

Assistant Secretary of the Treasury (Tax Policy).

Signed this 5th day of June, 2015.

Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: June 2, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: June 9, 2015.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Chapter 1

Accordingly, 26 CFR part 54 is amended as follows:

PART 54—PENSION EXCISE TAXES

■ **Paragraph 1.** The authority citation for part 54 continues to read in part as follows:

Authority: Authority: 26 U.S.C. 7805 * * *

Section 54.9815–2715 also issued under 26 U.S.C. 9833;

* * * * *

■ **Par. 2.** Section 54.9815–2715 is revised to read as follows:

§ 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 reenrollment.* 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 reenrollment.* 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.

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

Accordingly, 29 CFR part 2590 is amended as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 3. The authority citation for part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Secretary of Labor's Order 1–2011, 77 FR 1088 (January 9, 2012).

■ 4. Section 2590.715–2715 is revised to read as follows:

§ 2590.715–2715 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 reenrollment*. 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 § 2590.701–6) 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 reenrollment*. 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 § 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.* See § 2590.731. 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 § 2560.502c-2 of this chapter and 29 CFR part 2570, subpart C.

(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 § 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Subtitle A

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR part 147 as follows:

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 5. The authority citation for part 147 continues to read as follows:

Authority: Sections 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

■ 6. Revise § 147.200 to read as follows:

§ 147.200 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 or individual 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 reenrollment.* 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 § 146.117 of this subchapter) 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 reenrollment.* 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.

(iv) *SBC provided by a health insurance issuer offering individual health insurance coverage*—(A) *Upon application.* A health insurance issuer offering individual health insurance coverage must provide an SBC to an individual covered under the policy (including every dependent) upon receiving an application for any health insurance policy, 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)(iv)(D) of this section (relating to SBCs upon request), this paragraph (a)(1)(iv)(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 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)(iv)(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 individual no later than the first day of coverage.

(C) *Upon renewal, reissuance, or reenrollment.* If the issuer renews or reissues a policy, certificate, or contract of insurance for a succeeding policy year, or automatically re-enrolls an individual (or dependent) covered under a policy, certificate, or contract of insurance into a policy, certificate, or contract of insurance under a different plan or product, the issuer must provide an SBC for the coverage in which the individual (including every dependent) will be enrolled, as follows:

(1) If written application is required (in either paper or electronic form) for renewal, reissuance, or reenrollment, 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 policy year; however, 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.* A health insurance issuer offering individual health insurance coverage must provide an SBC to any individual or dependent upon request for an SBC or summary information about a health insurance product as soon as practicable, but in no event later than seven business days following receipt of the request.

(v) *Special rule to prevent unnecessary duplication with respect to individual health insurance coverage*—

(A) *In general.* If a single SBC is provided to an individual and any dependents at the individual's last known address, then the requirement to provide the SBC to the individual and any dependents is generally satisfied. However, if a dependent's last known address is different than the individual's last known address, a separate SBC is required to be provided to the dependent at the dependents' last known address.

(B) *Student health insurance coverage.* With respect to student health insurance coverage as defined at § 147.145(a), the requirement to provide an SBC to an individual will be considered satisfied for an entity if another party 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 covered individuals and dependents who are affected by the noncompliance regarding the noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

(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;

(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; and

(N) For qualified health plans sold through an individual market Exchange that exclude or provide for coverage of the services described in § 156.280(d)(1) or (2) of this subchapter, a notice of coverage or exclusion of such services.

(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 (or, in the case of individual market coverage, the average individual covered under a health insurance policy), not exceed four double-sided pages in length, and not include print smaller than 12-point font. A health insurance issuer offering individual health insurance coverage

must provide the SBC as a stand-alone document.

(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.

(iii) An issuer offering individual health insurance coverage must provide

an SBC in a manner that can reasonably be expected to provide actual notice in paper or electronic form.

(A) An issuer satisfies the requirements of this paragraph (a)(4)(iii) if the issuer:

(1) Hand-delivers a printed copy of the SBC to the individual or dependent;

(2) Mails a printed copy of the SBC to the mailing address provided to the issuer by the individual or dependent;

(3) Provides the SBC by email after obtaining the individual's or dependent's agreement to receive the SBC or other electronic disclosures by email;

(4) Posts the SBC on the Internet and advises the individual or dependent in paper or electronic form, in a manner compliant with paragraphs (a)(4)(iii)(A)(1) through (3) of this section, that the SBC is available on the Internet and includes the applicable Internet address; or

(5) Provides the SBC by any other method that can reasonably be expected to provide actual notice.

(B) 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 issuer notifies the individual or dependent that the SBC is available in paper form without charge upon request and provides it upon request.

(C) *Deemed compliance.* A health insurance issuer offering individual health insurance coverage that provides the content required under paragraph (a)(2) of this section, as specified in guidance published by the Secretary, to the federal health reform Web portal described in § 159.120 of this subchapter will be deemed to satisfy the requirements of paragraph (a)(1)(iv)(D) of this section with respect to a request for summary information about a health insurance product made prior to an application for coverage. However, nothing in this paragraph should be construed as otherwise limiting such issuer's obligations under this section.

(iv) An SBC provided by a self-insured non-Federal governmental plan may be provided in paper form. Alternatively, the SBC may be provided electronically if the plan conforms to either the substance of the provisions in paragraph (a)(4)(ii) or (iii) of this section.

(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 § 147.136(e) are met as applied to the SBC.

(b) *Notice of modification.* If a group health plan, or health insurance issuer offering group or individual 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 (or, in the case of individual market coverage, an individual covered under a health insurance policy) 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, and a health insurance issuer offering individual health insurance coverage must make available to applicants, policyholders, and covered dependents, 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 coinsurance, 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 (or, in the case of individual market coverage, an average individual covered under a health insurance policy).

(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.* For purposes of this section, the provisions of section 2724 of the PHS Act continue to apply with respect to preemption of State law. 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 health insurance issuer or a non-federal governmental health plan that willfully fails to provide information to a covered individual required under this section is subject to a fine of not more than \$1,000 for each such failure. A failure with respect to each covered individual constitutes a separate offense for purposes of this paragraph (e). HHS will enforce these provisions in a manner consistent with §§ 150.101 through 150.465 of this subchapter.

(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 § 147.140(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.

(3) For disclosures with respect to individuals and covered dependents in the individual market, this section is applicable to health insurance issuers beginning with respect to SBCs issued for coverage that begins on or after January 1, 2016.

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DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG-2015-0479]

Drawbridge Operation Regulation; Pearl River, LA/MS

AGENCY: Coast Guard, DHS.

ACTION: Notice of deviation from drawbridge regulations.

SUMMARY: The Coast Guard has issued a temporary deviation from the operating schedule that governs the operation of the US 90 highway bridge (East Pearl River Bridge), a swing span bridge across the Pearl River, mile 8.8 between Slidell, St. Tammany Parish, Louisiana and Pearlinton, Hancock County, Mississippi. The deviation is necessary in order to conduct electrical and structural repairs to the bridge. This deviation will allow the bridge to remain in the closed-to-navigation position for four consecutive days.

DATES: This deviation is effective from 7 a.m. on Monday, July 20, 2015, through 7 p.m. on Friday, July 24, 2015.

ADDRESSES: Documents mentioned in this preamble are part of docket [USCG-2015-0479]. To view documents

mentioned in this preamble as being available in the docket, go to <http://www.regulations.gov>, type the docket number (USCG-2015-0479) in the "SEARCH" box and click "SEARCH." Click on Open Docket Folder on the line associated with this rulemaking. You may also visit the Docket Management Facility in Room W12-140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary deviation, call or email Mr. Jim Wetherington, Bridge Administration Branch, Coast Guard; telephone 504-671-2128, email d8dpball@uscg.mil. If you have questions on viewing the docket, call Cheryl Collins, Program Manager, Docket Operations, telephone 202-366-9826.

SUPPLEMENTARY INFORMATION: Boh Bros. Construction Company, on behalf of the Louisiana Department of Transportation and Development, requested a temporary deviation from the operating schedule on the US 90 highway bridge (East Pearl River Bridge), a swing span bridge across the Pearl River, mile 8.8 between Slidell, St. Tammany Parish, Louisiana and Pearlinton, Hancock County, Mississippi. The bridge has a vertical clearance of 10 feet above mean high water in the closed-to-navigation position and unlimited clearance in the open-to-navigation position.

Navigation at the site of the bridge consists mainly of small tows with barges, some commercial sightseeing boats, and some recreational pleasure craft. Based on prior experience, as well as coordination with waterway users, it has been determined that this closure will not have a significant effect on these vessels. No alternate routes are available.

In accordance with 33 CFR 117.486(b), the draw of the US 90 highway bridge shall open on signal; except that, from 7 p.m. to 7 a.m. the draw shall open on signal if at least four hours notice is given. Vessels that do not require an opening will be allowed to pass at the slowest safe speed. The bridge will be unable to open in the event of an emergency.

The closure is necessary for the replacement of structural and electrical components of the draw span and two submarine cables. These operations will continue until completed and will not allow the normal operation of the bridge. Normal operations of the bridge will commence upon completion of the

work. Notices will be published in the Eighth Coast Guard District Local Notice to Mariners and will be broadcast via the Coast Guard Broadcast Notice to Mariners System.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the effective period of this temporary deviation. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: June 11, 2015.

David M. Frank,

Bridge Administrator, Eighth Coast Guard District.

[FR Doc. 2015-14715 Filed 6-15-15; 8:45 am]

BILLING CODE 9110-04-P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG-2015-0534]

Drawbridge Operation Regulation; Bayou Sara, Near Saraland, Mobile County, AL

AGENCY: Coast Guard, DHS.

ACTION: Notice of deviation from drawbridge regulations.

SUMMARY: The Coast Guard has issued a temporary deviation from the operating schedule that governs the CSX Railway Company swing span bridge across Bayou Sara, mile 0.1, near Saraland, Mobile County, Alabama. The deviation is necessary to complete scheduled core borings behind the fender system of the bridge. This deviation will allow the bridge to remain in the closed-to-navigation position for 24 consecutive hours.

DATES: This deviation is effective from 6 a.m. on June 29, 2015 until 6 a.m. on June 30, 2015.

ADDRESSES: Documents mentioned in this preamble are part of docket [USCG-2015-0534]. To view documents mentioned in this preamble as being available in the docket, go to <http://www.regulations.gov>, type the docket number (USCG-2015-0534) in the "SEARCH" box and click "SEARCH." Click on Open Docket Folder on the line associated with this rulemaking. You may also visit the Docket Management Facility in Room W12-140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m.,