2017 Summary of Benefits & Coverage
Templates & Updates

October 2016

Brought to you by *Sullivan Benefits & United Benefit Advisors*

A Summary of Benefits and Coverage (SBC) is two-and-a-half page (double-sided) communication required by the federal government. It must contain specific information, in a specific order, and with a minimum size type, about a group health benefit's coverage and limitations.

On April 6, 2016, the Centers for Medicare and Medicaid Services (CMS), the Department of Labor (DOL), and the Department of the Treasury issued the final 2017 summary of benefits and coverage (SBC) template, group and individual market SBC instructions, uniform glossary of coverage and medical terms, a coverage example calculator, and calculator instructions.

The SBC is to be used by all health plans, including individual, small group, and large group; insured and self-insured; grandfathered, transitional, and ACA compliant. The new SBC must be used for plan years with open enrollment periods beginning after April 1, 2017. It will not be used for marketplace plans for the 2017 coverage year.

For fully insured plans, the insurer is responsible for providing the SBC to the plan administrator (usually this is the employer). The plan administrator and the insurer are both responsible for providing the SBC to participants, although only one of them actually has to do this.

For self-funded plans, the plan administrator is responsible for providing the SBC to participants. Assistance may be available from the plan administrator's TPA, advisor, etc., but the plan administrator is ultimately responsible. (The plan administrator is generally the employer, not the claims administrator.)

Changes

The template includes a new "important question" that asks "Are there services covered before you meet your deductible?" and requires family plans to disclose whether or not the plan has embedded deductibles or out-of-pocket limits. This is reported in the "Why This Matters" column in relation to the question "what is the overall deductible?" and plans must list "If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible has been met" or alternatively, "If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay."

Tiered networks must be disclosed and the question "Will you pay less if you use a network provider?" is now included. The SBC also includes language that warns participants that they could receive out-of-network providers while they are in an in-network facility. The SBC also indicates that a consumer could receive a "balance bill" from an out-of-network provider.

The "explanatory coverage page" was dropped from the template.

The coverage examples provided clarify the "having a baby" example and the "managing type 2 diabetes" example, in addition to providing a third example of "dealing with a simple fracture." The coverage example

must be calculated assuming that a participant does not earn wellness credits or participate in an employer's wellness program. If the employer has a wellness program that could reduce the employee's costs, the employer must include the following language: "These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert]."

The column for "Limitations, Exceptions, & Other Important Information" must contain core limitations, which include:

- When a service category or a substantial portion of a service category is excluded from coverage (that is, the column should indicate "brand name drugs excluded" in health benefit plans that only cover generic drugs);
- When cost sharing for covered in-network services does not count toward the out-of-pocket limit;
- Limits on the number of visits or on specific dollar amounts payable under the health benefit plan; and
- When prior authorization is required for services.

The template and instructions indicate that qualified health plans (those certified and sold on the Marketplace) that cover excepted abortions (such as those in cases of rape or incest, or when a mother's life is at stake) and plans that cover non-excepted abortion services must list "abortion" in the covered services box. Plans that exclude abortion must list it in the "excluded services" box, and plans that cover only excepted abortions must list in the "excluded services" box as "abortion (except in cases of rape, incest, or when the life of the mother is endangered)." Health plans that are not qualified health plans are not required to disclose abortion coverage, but they may do so if they wish.

Sullivan Benefits is here to keep you updated on the latest industry news and trends. For additional resources and guidance, never hesitate to contact any member of the Sullivan Benefits Team.

Source: United Benefit Advisors