# FAQs Regarding Summary of Benefits and Coverage Released; No Penalties for Plans and Issuers in Good Faith Compliance During the First Year of Applicability

On March 19, 2012, the U.S. Department of Labor posted the eighth in a series of FAQs on open questions under the Patient Protection and Affordable Care Act (ACA). The FAQs, which were prepared jointly by the Departments of Labor, Health and Human Services, and Treasury (the Departments), provide additional guidance on the implementation of the requirement that insurers and group health plans provide a summary of benefits and coverage (SBC). The FAQs are available here.

As detailed in our prior alert, on February 9, 2012, the Departments issued final regulations under section 2715 of the Public Health Service Act, which requires insurers and group health plans (other than those that provide excepted benefits) to provide an SBC to consumers, participants and beneficiaries.

Notably, the FAQs provide that, during the first year of applicability, the Departments will not impose penalties on plans and insurers that are working diligently and in good faith to provide the required SBC content in a manner that is consistent with the final regulations. The FAQs also state that the Departments do not anticipate making any significant changes to the SBC template for 2014, although the Departments noted certain "discrete changes" that will be necessary after the first year of applicability, as well as the possibility of additional refinements that may be made in response to other requests from plans and insurers.

In addition to the good faith compliance standard for the first year of applicability, the 24 FAQs respond to questions that have arisen since the issuance of the final regulations. In particular, the FAQs:

- Permit plan and insurers to combine information for different coverage tiers, cost-sharing selections (such as levels of deductibles, copayments and coinsurance) and add-ons to major medical coverage (such as a health flexible spending arrangement) in a single SBC, as long as the appearance is understandable.
- Provide that, until further guidance is issued, insured group health plans are not subject to enforcement action for failure to provide a complete or timely SBC under certain circumstances involving "carve-out arrangements" (such as pharmacy benefit managers).
- Clarify that COBRA qualified beneficiaries have the same rights to receive an SBC as similarly-situated non-COBRA beneficiaries.
- Allow group health plans to reflect the coverage period for the group health plan as a whole, rather than for each individual participant.
- Permit plans and insurers to voluntarily provide information about premiums and grandfathered status.
- Provide additional guidance on providing the SBC in an electronic format and in a culturally and linguistically appropriate manner.

If you have any questions about the details provided in these FAQs or about preparing your SBCs or about Affordable Care Act implementation generally, please contact a member of the Ropes & Gray employee benefits practice or your usual Ropes & Gray advisor. For access to other information about the Affordable Care Act, please visit the Ropes & Gray Health Reform Resource Center.