

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XIX)

May 2, 2014

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of various provisions of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform/> and <http://www.cms.gov/cciiio/resources/fact-sheets-and-faqs/index.html>), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

Updated Department of Labor Model Notices

In general, under the Consolidated Omnibus Budget Reconciliation Act (COBRA), an individual who was covered by a group health plan on the day before the occurrence of a qualifying event (such as a termination of employment or a reduction in hours that causes loss of coverage under the plan) may be able to elect COBRA continuation coverage upon that qualifying event.¹ Individuals with such a right are referred to as qualified beneficiaries.

Under COBRA, group health plans must provide covered employees and their families with certain notices explaining their COBRA rights. A group health plan must provide each covered employee and spouse (if any) with a written notice of COBRA rights “at the time of commencement of coverage” under the plan (general notice). A group health plan must also provide qualified beneficiaries with a notice which describes their rights to COBRA continuation coverage and how to make an election (election notice).

General Notice: The general notice must be furnished to each covered employee (and their spouse if covered under the plan) not later than the earlier of: (1) 90 days from the date on which the covered employee or spouse first becomes covered under the plan or, if later, the date on which the plan first becomes subject to the continuation coverage requirements; or (2) the date on which the administrator is required to furnish an election notice to the employee or to his or her spouse or dependent. The general notice is required to include:

- The name of the plan and the name, address, and telephone number of someone whom the employee and spouse can contact for more information on COBRA and the plan;
- A general description of the continuation coverage provided under the plan;
- An explanation of what qualified beneficiaries must do to notify the plan of qualifying events or disabilities;
- An explanation of the importance of keeping the plan administrator informed of addresses of the participants or beneficiaries; and

¹ For more information on COBRA continuation coverage requirements applicable to group health plans, see “An Employer’s Guide to Group Health Continuation Coverage Under COBRA,” available at www.dol.gov/ebsa/publications/cobraemployer.html.

- A statement that the general notice does not fully describe COBRA or the plan and that more complete information is available from the plan administrator and in the plan's summary plan description (SPD).

Election Notice: The election notice must be provided to the qualified beneficiaries within 14 days after the plan administrator receives notice that a qualifying event has occurred. The election notice is required to include:

- The name of the plan and the name, address, and telephone number of the plan's COBRA administrator;
- Identification of the qualifying event;
- Identification of the qualified beneficiaries (by name or by status);
- An explanation of the qualified beneficiaries' right to elect COBRA continuation coverage;
- The date coverage will terminate (or has terminated) if COBRA continuation coverage is not elected;
- How to elect COBRA continuation coverage;
- What will happen if COBRA continuation coverage isn't elected or is waived;
- What COBRA continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events;
- How COBRA continuation coverage might terminate early;
- Premium payment requirements, including due dates and grace periods;
- A statement of the importance of keeping the plan administrator informed of the addresses of qualified beneficiaries; and
- A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the plan administrator and in the plan's SPD.

Some qualified beneficiaries may want to consider and compare health coverage alternatives to COBRA continuation coverage, such as coverage that is available through the Health Insurance Marketplace (Marketplace). Qualified beneficiaries may be eligible for a premium tax credit (a tax credit to help pay for some or all of the cost of coverage in plans offered through the Marketplace) and cost-sharing reductions (amounts that lower out-of-pocket costs for deductibles, coinsurance, and copayments), and may find that Marketplace coverage is more affordable than COBRA.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) specifies that an employer that maintains a group health plan in a State that provides premium assistance² for the purchase of coverage under a group health plan is required to notify each employee of potential opportunities currently available for premium assistance in the State in which the employee resides.³

² The CHIPRA notice requirement applies to an employer that maintains a group health plan in a State that provides premium assistance under a State Medicaid plan under title XIX of the Social Security Act (SSA), or child health assistance under a State child health plan under title XXI of the SSA.

³ The Department of Labor provided guidance regarding this notice requirement and announced the availability of a model notice on February 4, 2010 at 75 FR 5808.

The Department of Labor has model notices that plans may use to satisfy the requirement to provide the general notice and election notice under COBRA, and the notice regarding premium assistance under CHIPRA. The COBRA model election notice was revised on May 8, 2013 to help make qualified beneficiaries aware of other coverage options that would soon become available in the Marketplace. Today, DOL is issuing a Notice of Proposed Rulemaking, as well as updated versions of the model general notice and model election notice that reflect that the Marketplace is now open and that better describes special enrollment rights in Marketplace coverage. DOL is also issuing a revised CHIPRA notice with similar updates related to Marketplace coverage.

Q1: Where can I get a copy of the Department of Labor’s newest model notices?

The model general notice and model election notice are available on the DOL website at www.dol.gov/ebsa/cobra.html and the model CHIPRA notice is available at http://www.dol.gov/ebsa/compliance_assistance.html. (The model notices are available in modifiable, electronic form). As with the earlier model notices, in order to use the model properly, the plan administrator must complete it by filling in the blanks with the appropriate plan information.

Contemporaneous with the issuance of these FAQs, DOL is also issuing a notice of proposed rulemaking to update its regulations with respect to the COBRA model notices. Until rulemaking is finalized and effective, DOL will consider use of the model notices available on its website, appropriately completed, to constitute compliance with the notice content requirements of COBRA.

Limitations on Cost-Sharing under the Affordable Care Act

Public Health Service (PHS) Act section 2707(b), as added by the Affordable Care Act, provides that a non-grandfathered group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under sections 1302(c)(1) of the Affordable Care Act. Section 1302(c)(1) limits an enrollee’s out-of-pocket costs.⁴

For plan or policy years beginning in 2014, the annual limitation on out-of-pocket costs in effect under Affordable Care Act section 1302(c)(1) is \$6,350 for self-only coverage and \$12,700 for coverage other than self-only coverage. Beginning with the 2015 plan or policy year and for plan or policy years thereafter, the annual limitation on out-of-pocket costs is increased by the premium adjustment percentage described under Affordable Care Act section 1302(c)(4). HHS has proposed that after applying the premium adjustment percentage, the annual limitation on out-of-pocket costs for 2015 would be \$6,600 for self-only coverage and \$13,200 for coverage other than self-only coverage.⁵

⁴ The annual limitation on out-of-pocket costs is also applied to non-grandfathered individual market coverage through the essential health benefits package requirements of PHS Act section 2707(a). On April 1, 2014, Public Law No. 113-93 was enacted. Section 213 of that law repeals the limitation on deductibles in the small group market that was previously required in this market under section 2707(b) of the PHS Act and section 1302(c)(2) of the Affordable Care Act.

⁵ Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule, 79 FR 15808 (Mar. 21, 2014).

Previous FAQs provided guidance on out-of-pocket maximums.⁶ Set forth below are FAQs addressing additional questions about out-of-pocket maximums.

Q2: If an out-of-network provider charges an amount greater than the plan’s or issuer’s allowed amount, does individual spending for the amount in excess of the allowed amount (also known as balance billing) count toward the out-of-pocket maximum?

The Departments previously stated in an FAQ⁷ that if a plan includes a network of providers, the plan may, but is not required to, count out-of-pocket spending for out-of-network items and services towards the plan’s annual out-of-pocket maximum. A plan that counts such spending towards the out-of-pocket maximum may use any reasonable method for doing so. For example, if the plan covers 75% of the usual, customary, and reasonable amount (UCR) charged for services provided out-of-network and the participant pays the remaining 25% of UCR plus any amount charged by the out-of-network provider in excess of UCR, the 25% of UCR paid by the participant may reasonably be counted, in full or in part, toward the out-of-pocket maximum without including any amount charged above UCR paid by the participant.

Q3: With respect to the annual out-of-pocket maximum, how should large group market coverage and self-insured group health plans treat an individual’s out-of-pocket costs for a brand name prescription drug, in circumstances in which a generic was available and medically appropriate?

As the Departments previously stated in guidance on how to apply annual and lifetime dollar limits under section 2711 of the Public Health Service Act,⁸ large group market coverage and self-insured group health plans have discretion to define “essential health benefits.” For example, a plan may include only generic drugs, if medically appropriate (as determined by the individual’s personal physician) and available, while providing a separate option (not as part of essential health benefits) of electing a brand name drug at a higher cost sharing amount. If, under this type of plan design, a participant or beneficiary selects a brand name prescription drug in circumstances in which a generic was available and medically appropriate (as determined by the individual’s personal physician), the plan may provide that all or some of the amount paid by the participant or beneficiary (e.g., the difference between the cost of the brand name drug and the cost of the generic drug) is not required to be counted towards the annual out-of-pocket maximum. For ERISA plans, the SPD must explain which covered benefits will not count towards an individual’s out-of-pocket maximum.

In determining whether a generic is medically appropriate, a plan may use a reasonable exception process. For example, the plan may defer to the recommendation of an individual’s

⁶ See Affordable Care Act Implementation FAQs, Part XII, Q2, available at <http://www.dol.gov/ebsa/faqs/faq-aca12.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html; Affordable Care Act Implementation FAQs, Part XVIII, Q2-Q5, available at <http://www.dol.gov/ebsa/faqs/faq-aca18.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html.

⁷ See ACA Implementation FAQs Part XVIII, Q4, available at www.dol.gov/ebsa/faqs/faq-aca18.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html.

⁸ CMS, **Frequently Asked Questions on Essential Health Benefits Bulletin, Q10** (February 17, 2012) <http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>

personal physician, or it may offer an exceptions process meeting the requirements of 45 CFR 156.122(c).

For non-grandfathered health plans in the individual and small group markets that must provide coverage of the essential health benefit package under section 1302(a) of the Affordable Care Act, additional requirements apply.

Q4: If large group market coverage or self-insured group health plan has a reference-based pricing structure, under which the plan pays a fixed amount for a particular procedure (for example, a knee replacement), which certain providers will accept as payment in full, how does the out-of-pocket limitation apply when an individual uses a provider that does not accept that amount as payment in full?

Reference pricing aims to encourage plans to negotiate cost effective treatments with high quality providers at reduced costs. At the same time, the Departments are concerned that such a pricing structure may be a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and an adequate network of providers.

Accordingly, the Departments invite comment on the application of the out-of-pocket limitation to the use of reference based pricing. The Departments are particularly interested in standards that plans using reference-based pricing structures should be required to meet to ensure that individuals have meaningful access to medically appropriate, quality care. Please send comments by August 1, 2014 to E-OHPSCA-FAQ.ebsa@dol.gov.

Until guidance is issued and effective, with respect to a large group market plan or self-insured group health plan that utilizes a reference-based pricing program, the Departments will not consider a plan or issuer as failing to comply with the out-of-pocket maximum requirements of PHS Act section 2707(b) because it treats providers that accept the reference amount as the only in-network providers, provided the plan uses a reasonable method to ensure that it provides adequate access to quality providers.

For non-grandfathered health plans in the individual and small group markets that must provide coverage of the essential health benefit package under section 1302(a) of the Affordable Care Act, additional requirements apply.

Coverage of Preventive Services

PHS Act section 2713 and the interim final regulations relating to coverage of preventive services⁹ require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to provide benefits for, and prohibit the imposition of cost-sharing requirements with respect to, the following:

- Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF

⁹ 75 FR 41726 (July 19, 2010).

regarding breast cancer screening, mammography, and prevention issued in or around November 2009, which are not considered current;

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.¹⁰

If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques to determine any such coverage limitations.¹¹

These requirements do not apply to grandfathered health plans.¹²

Q5: The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. What are plans and issuers expected to provide as preventive coverage for tobacco cessation interventions?

As stated earlier, plans may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified in the recommendation or guideline regarding that preventive service. Evidence-based clinical practice guidelines can provide useful guidance for plans and issuers.¹³ The Departments will consider a group health plan or health insurance issuer to be in compliance with the

¹⁰ “Women’s Preventive Services: Required Health Plan Coverage Guidelines” (HRSA Guidelines) were adopted and released on August 1, 2011, based on recommendations developed by the Institute of Medicine (IOM) at the request of HHS. These recommended women’s preventive services are required to be covered without cost-sharing, for plan years (or, in the individual market, policy years) beginning on or after August 1, 2012.

¹¹ See 29 CFR 2590.715-2713(a)(4) and 45 CFR 147.130(a)(4).

¹² In addition, the HRSA Guidelines exempt group health plans established or maintained by certain religious employers (and any group health insurance coverage provided in connection with such plans) from any requirement to cover contraceptive services that would otherwise apply. Additionally, accommodations are available for group health plans (and any group health insurance coverage provided in connection with such plans) established or maintained by certain non-grandfathered, non-profit eligible organizations with religious objections to contraceptive services with respect to the requirement to cover contraceptive services. See 78 FR 39870 (July 2, 2013) and <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/preventive-services-guidance-6-28-2013.pdf>.

¹³ See, e.g., Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, available at: <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html#Clinic>. See also Centers for Disease Control and Prevention, Coverage for Tobacco Use Cessation Treatments, available at: http://www.cdc.gov/tobacco/quit_smoking/cessation/pdfs/coverage.pdf, for a discussion of scientific evidence regarding barriers for tobacco users accessing proven cessation treatments.

requirement to cover tobacco use counseling and interventions, if, for example, the plan or issuer covers without cost-sharing:

1. Screening for tobacco use; and,
2. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
 - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
 - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

This guidance is based on the Public Health Service-sponsored Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update, available at: <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html#Clinic>.

Health FSA Carryover and Excepted Benefits

Excepted benefits provided under a group health plan or health insurance coverage generally are exempt from the Health Insurance Portability and Accountability Act (HIPAA) and Affordable Care Act market reform requirements of the Employee Retirement Income Security Act (ERISA), the PHS Act, and the Code.¹⁴ Under previous regulations issued by the Departments, (the HIPAA excepted benefits regulations)¹⁵ health FSAs generally constitute excepted benefits if:

1. The employer also makes available group health plan coverage that is not limited to excepted benefits for the year to the class of participants by reason of their employment; and
2. The arrangement is structured so that the maximum benefit payable to any employee participant in the class cannot exceed:
 - a. Two times the employee's salary reduction election for the arrangement for the year; or,
 - b. If greater, cannot exceed \$500 plus the amount of the participant's salary reduction election).

¹⁴ Note, to the extent a health FSA is not excepted benefits, the Departments' interim final rules provide that PHS Act section 2711's annual limits requirements do not apply to health FSAs. See 29 CFR 2590.715-2711(a)(2)(ii) and 45 CFR 147.126(a)(2)(ii). Moreover, to the extent a health FSA is not excepted benefits, but is integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of PHS Act section 2713, the fact that benefits under the health FSA by itself are limited does not violate PHS Act section 2713 because the combined benefit satisfies the requirements. Other market reforms, such as PHS Act section 2719 regarding internal claims and appeals and external review do apply, however, apply to FSA coverage that is not excepted benefits.

¹⁵ See 26 CFR 54.9831-1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), and 45 CFR 146.145(c)(3)(v).

On October 31, 2013, the Department of the Treasury and Internal Revenue Service issued guidance¹⁶ modifying the “use-or-lose” rule for health FSAs to allow up to \$500 of unused amounts remaining at the end of a plan year in a health FSA to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year, provided that the plan does not also incorporate a grace period. The guidance provided that the carryover of up to \$500 does not affect the maximum amount of salary reduction contributions that the participant is permitted to make under section 125(i) of the Code (\$2,500 adjusted for inflation after 2012).

Q6: How is a permissible carryover amount for a health FSA taken into account with regards to the maximum benefits payable limit for health FSAs under the excepted benefit regulations?

Unused carry over amounts remaining at the end of a plan year in a health FSA that satisfy the modified “use-or-lose” rule should not be taken into account when determining if the health FSA satisfies the maximum benefit payable limit prong under the excepted benefits regulations.

Summary of Benefits and Coverage

PHS Act section 2715, as added by the Affordable Care Act and incorporated by reference into ERISA and the Code, directs the Departments 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.” On February 14, 2012, the Departments published final regulations regarding the SBC.¹⁷ At the same time, the Departments published a notice announcing the availability of templates, instructions, and related materials authorized for implementing the disclosure provisions under PHS Act section 2715 for the first year of applicability (that is, for SBCs and the uniform glossary provided with respect to coverage beginning before January 1, 2014).¹⁸

The Departments stated that updated materials would be issued for later years.¹⁹ The Departments issued FAQs in April 2013 providing guidance for SBCs provided with respect to coverage beginning on or after January 1, 2014, and before January 1, 2015 (“the second year of applicability”).²⁰

Q7: What templates should plans and issuers use for the SBCs and the uniform glossary required to be provided after the second year of applicability?

¹⁶ See IRS Notice 2013-71, available at <http://www.irs.gov/pub/irs-drop/n-13-71.pdf>.

¹⁷ See 26 CFR 54.9815-2715, 29 CFR 2590.715-2715, and 45 CFR 147.200, published at 77 FR 8668 (February 14, 2012).

¹⁸ See 77 FR 8706 (February 14, 2012).

¹⁹ See *id.* at 8707. See also ACA Implementation FAQs, Part VIII, Q24, 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.

²⁰ See ACA Implementation FAQs 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.

An updated SBC template (and sample completed SBC) were made available at <http://cciio.cms.gov> and <http://www.dol.gov/ebsa/healthreform> in April 2013 for the second year of applicability. Until further guidance is issued, these documents continue to be authorized. There are no changes to the uniform glossary or the “Why This Matters” language for the SBC. There are also no changes to the Instructions for Completing the SBC (for either group or individual health coverage, as applicable), including the special rule providing that, “[t]o the extent a plan’s terms that are required to be described in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible.”

Q8: Certain specific safe harbors and other enforcement relief were provided by the Departments related to the requirement to provide an SBC and a uniform glossary for the first and second years of applicability.²¹ Will this relief be extended?

Yes. As stated in previous FAQs,²² the Departments’ basic approach to Affordable Care Act implementation is to work together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is, and will continue to be, marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law.”

Until further guidance is provided, previously-issued enforcement and transition relief guidance continues to apply with respect to:

- Affordable Care Act Implementation FAQs Part VIII, Q2 (regarding the Departments’ basic approach to implementation of the SBC requirements during the first year of applicability);²³
- Affordable Care Act Implementation FAQs Part VIII, Q5 (regarding use of carve-out arrangements);²⁴
- Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);²⁵

²¹ See ACA Implementation FAQs Part XIV, Q5, 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.

²² See ACA Implementation FAQs Part I, Q1 (available at www.dol.gov/ebsa/faqs/faq-aca.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html); FAQs Part VIII Q2 (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); and FAQs Part IX Q8 (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).

²³ Available at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

²⁴ Available at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

²⁵ 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.

- Affordable Care Act Implementation FAQs Part IX, Q8 (regarding penalties for failure to provide the SBC or uniform glossary);²⁶
- Affordable Care Act Implementation FAQs Part IX, Q9 (regarding the coverage examples calculator);²⁷ and related information related to use of the coverage examples calculator;²⁸
- Affordable Care Act Implementation FAQs Part IX, Q10 (regarding an issuer's obligation to provide an SBC with respect to benefits it does not insure);²⁹
- Affordable Care Act Implementation FAQs Part IX, Q13 (regarding expatriate coverage);³⁰
- Affordable Care Act Implementation FAQs Part X, Q1 (regarding Medicare Advantage);³¹
- Affordable Care Act Implementation FAQs Part XIV, Q2 (regarding providing information about MEC and MV without changing the SBC template);³²
- Affordable Care Act Implementation FAQs Part XIV, Q3 (removal of the row on the SBC template related to annual limits information);³³
- Affordable Care Act Implementation FAQs Part XIV, Q6 (an enforcement safe harbor related to closed blocks of business);³⁴
- Affordable Care Act Implementation FAQs Part XIV, Q7 (regarding the anti-duplication rule for student health insurance coverage);³⁵ and
- The Special Rule contained in the Instruction Guides for Group and Individual Coverage.³⁶

²⁶ 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.

²⁷ 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.

²⁸ 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.

²⁹ 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.

³⁰ 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. See also FAQs Part XIII, available at <http://www.dol.gov/ebsa/faqs/faq-aca13.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs13.html.

³¹ 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.

³² 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.

³³ 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.

³⁴ 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.

³⁵ 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.

³⁶ See What This Plan Covers and What it Costs: Instruction Guide for Group Coverage, February 2012 edition (available at <http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf> and <http://www.cms.gov/CCIIO/Resources/Files/Downloads/instructions-group-final.pdf>) and What This Plan Covers and What it Costs: Instruction Guide for Individual Health Insurance Coverage, February 2012 edition (available at <http://www.dol.gov/ebsa/pdf/SBCInstructionsIndividual.pdf> and <http://www.cms.gov/CCIIO/Resources/Files/Downloads/instructions-individual-final.pdf>).

This guidance supersedes any previous subregulatory guidance (including FAQs) stating that certain enforcement relief for the SBC and uniform glossary requirements is limited to the first or second year of applicability.