



EMPLOYER GUIDE

SUMMARY OF BENEFITS AND COVERAGE

GLOSSARY OF HEALTH COVERAGE AND MEDICAL TERMS



Summary of Benefits and Coverage

On Feb. 14, 2012, the Departments of Treasury, Internal Revenue Service, Labor, Health and Human Services, and Employee Benefits Security Administration released a final rule that implemented disclosure requirements under section 2715 of the Public Health Service Act.

This health insurance market reform under the Patient Protection and Affordable Care Act requires group health plans and health insurance issuers in the group market to provide a summary of benefits and coverage and uniform glossary to members of their health plans.

Final Regulations were again issued in June 2015. A revised SBC template and uniform glossary is expected to be finalized in early 2016 and take effect in January 2017.

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What's an SBC and a Uniform Glossary?

The Summary of Benefits and Coverage or "SBC" and Glossary of Health Coverage and Medical Terms or "Uniform Glossary" are designed to help consumers better understand their health coverage and allow for easy comparison of other coverage options when shopping, applying, enrolling and re-enrolling into a health plan. The SBC is a resource for your employees that will summarize your health plan options including:

- Deductible
- Out-of-pocket and annual limits
- In- and out-of-network provider coverage
- Coverage of common medical events
- Excluded services
- Common covered services
- Rights to continue coverage
- Member grievance and appeal rights
- Coverage examples for having a baby and managing type 2 diabetes

The "Uniform Glossary" lists commonly used terms in insurance coverage. You can access the glossary by logging on to www.aultcare.com.

Insurance Company 1: Plan Option 1		Coverage Period: 01/01/2013 – 12/31/2013
Summary of Benefits and Coverage: What this Plan Covers & What it Costs		Coverage for: Individual + Spouse Plan Type: PPO
 This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].		
Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 person / \$1,000 family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes. \$300 for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers \$2,500 person / \$5,000 family For non-participating providers \$4,000 person / \$8,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.[insert].com or call 1-800-[insert] for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .
Questions: Call 1-800-[insert] or visit us at www.[insert] . If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.		

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
 Corrected on May 11, 2012

What is Culturally and Linguistically Appropriate Manner?

This requirement provides employees and dependents the option to request their SBC in a non-English language if they reside in a county that meets or exceeds a 10 percent threshold of non-English speaking residents. The SBC that we provide will contain directions for non-English speaking individuals to receive further information in their non-English language.

How do I meet the Electronic Disclosure requirements to distribute the SBC to my employees?

Under the Department of Labor Electronic Disclosure requirement, if your employees are able to effectively access documents provided in electronic format at their worksite (i.e. e-mail) and this access is a part of their duties as an employee, you can send the SBC to them electronically. You can also allow the employees to elect to receive their SBC electronically.

Eligible employees (not currently enrolled) can receive the SBC electronically as long as a paper version option is available upon request. You can accomplish this by email, e-card, posting on your intranet or sending a postcard.

What happens if I fail to comply?

POTENTIAL FINES AND PENALTIES

- Up to \$1,000 per day for each instance of willing non-compliance
- A fine of \$100 per day per affected individual until compliant

Who will provide me with the materials I need for distribution to my employees?

As your health issuer or third-party administrator, we are committed to providing you with the tools that you need to meet this regulatory requirement.

- We will provide you with an SBC master copy for distribution (electronically or paper copy) for your employees, dependents and eligible employees for health insurance coverage. This will include an SBC for each benefit package you offer and a new SBC when coverage changes.
- Continuously monitor changes to regulation that may impact you.

When will I receive my SBC?

We will deliver your SBC to you at the following times:

- Upon my application for coverage or within 7 days
- Within 7 days upon my request
- If terms of my plan are not yet final, upon the first day of coverage
- Upon changes to my plan
- If automatically re-enrolled, a new SBC will be provided at that re-enrollment

Who should receive the SBC?

If you have an employee and all of the dependents reside at one address, only one SBC is required to be distributed.

However, if an employee has dependents who have an alternate address, you are required to distribute an SBC to those alternate addresses.

You are also required to distribute an SBC to **all of your employees who are eligible for health insurance coverage, even if they are not currently enrolled in your health plan.**

When do I need to distribute the materials?

OPEN ENROLLMENT

You need to provide the SBC with open enrollment materials. If you do not hold an open enrollment period, provide the SBC no later than the first date your employees are eligible to enroll for coverage.

ONLINE ENROLLMENT

If you offer online enrollment, you are permitted to provide the SBC at the time of online enrollment or online renewal of coverage electronically but must provide the option to receive a paper copy.

AUTOMATIC RENEWAL

If you have an automatic renewal, the SBC must be provided 30 days prior to the first day of the new plan year. This SBC will reflect the plan that the employee and dependents are currently enrolled.

UPON REQUEST

If you have an employee or dependent who requests an SBC or Uniform Glossary, you must fulfill the request within seven business days. If the request is online, then you can deliver it electronically but you must provide the option to receive a paper copy.

SBC CHANGES

If the SBC changes from what was distributed at enrollment, you must provide an updated SBC prior to the first day of coverage.

SPECIAL ENROLLMENT

For Special Enrollment, you must provide an SBC within 90 days after they enrolled in your plan.

MIDYEAR BENEFIT CHANGES

If you make a midyear change to your plan that changes the content of your SBC, you must provide a 60-day advance notice to employees. This can be complete via a new SBC or a separate notice (summary of material modification).

Frequently Asked Questions

1. *Does this regulation impact small and large groups?*

Yes. Whether you are a small or large employer group, the SBC requirements apply to your health plan.

2. *Does this apply to both fully insured and self-insured plans?*

Yes, this impacts both fully insured and self-insured plans.

3. *Am I exempt because I am in a “grandfathered” plan?*

No, the SBC requirement applies to both “grandfathered” and “non-grandfathered” plans.

4. *Do I need an SBC for stand-alone dental or vision benefits?*

No, the SBC regulations do not apply to stand-alone excepted benefits. Excepted benefits are generally benefits that require the individual to pay an additional premium.

5. *Can I combine the SBC and Uniform Glossary with other documents?*

Yes, as long as the SBC is displayed at the beginning.

6. *Do COBRA enrollees receive SBCs?*

Yes, COBRA enrollees have the same rights as other enrollees to receive SBCs.

7. *Do I have to provide the SBC and Uniform Glossary in color?*

No, you are permitted to provide in color or grayscale.