Summary of Benefits and Coverage
FACT SHEET
Updated 7/23/12

This fact sheet provides a high-level overview of the **Summary of Benefits and Coverage (SBC)** mandated by the Patient Protection and Affordable Care Act (PPACA).

OVERVIEW

The Departments of Health and Human Services (HHS), Labor and Treasury issued regulations requiring health plans to provide a SBC and Uniform Glossary that clearly explain benefits and coverage within a standardized template with uniform language beginning 9/23/12. To develop these standards, the PPACA required the regulators named above to consult with the National Association of Insurance Commissioners (NAIC). The NAIC developed a template SBC, as well as a Uniform Glossary of commonly used health insurance terms, along with regulations detailing rules for when and how these documents must be provided to individuals and employer groups.

The SBC and Uniform Glossary must be distributed for insured commercial products offered to direct pay individuals, including Healthy New York, and insured employer groups. The insurer is not obligated to supply the SBC and Uniform Glossary to self-funded employer groups. Medicaid, Family Health Plus, Child Health Plus, Medicare Advantage and Medicare Supplemental, stand-alone Dental, and stand-alone Vision products are excluded from the SBC and Uniform Glossary requirements.

REGULATIONS

A SBC must be provided to insured employer groups and direct pay individuals in writing and free of charge under several different circumstances, such as upon application for coverage, by the first day of coverage (if information in the SBC has changed), upon renewal, and upon request. PPACA requires that a SBC must be provided to applicants, enrollees, and policy or certificate holders. PPACA places responsibility to provide a SBC on the health plan and/or the employer group as follows:

- **For delivery to an insured employer group:** The health plan.
- **For delivery to members of insured employer groups:** The employer group and the health plan.
- **For delivery to members of self-insured employer groups:** The employer group or designated employer plan administrator of the plan as that term is defined under ERISA.

HHS has acknowledged that this will be a significant change for the marketplace and has agreed that good-faith efforts to comply with this mandate will be accepted. It will be important for employer groups and insurers to work together during this first year of SBC compliance to work out any challenges and issues that may arise. HHS guidelines can be found at http://www.dol.gov/ebsa/faqs/faq-aca9.html.

SBC PROVIDED BY HEALTH PLAN TO AN EMPLOYER GROUP

The regulations requires a health plan to provide a SBC to an insured employer group upon an application for coverage, or as soon as practicable following receipt of the application, but in no event later than 7 business days following receipt of the application. If there is any change to the information in the SBC before the first day of coverage, the health plan must update and provide a revised SBC to the employer group no later than the first day of coverage. The SBC must be provided upon request no later than 7 business days after receipt of the request.

The SBC must be provided upon renewal as follows:

- **Renewal when a re-application is required:** The SBC must be provided no later than the date on which the materials are distributed.
- **Automatic Renewal:** The SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.

SBC PROVIDED BY HEALTH PLAN TO INDIVIDUALS

The regulations requires the employer groups and the health plan (for insured membership) to provide to each participant the SBC(s) for each benefit package the participant is eligible to select as part of application materials no later than the first date on which the individual is eligible to enroll. If there is any change to the information required in the SBC before the first day of coverage, an updated SBC must be provided no later than the first day of coverage. The SBC must be provided upon renewal and upon request. In order to reduce duplication, a single SBC may be provided to a family unless any individuals in the family are known to reside at a different address.

univera HEALTHCARE an excellus company

SBC CONTENT

The regulation outlines the required content elements and format requirements for the SBC. These requirements include:

- A description of the coverage (including the cost-sharing), for each category of benefits identified in the template SBC;
- The exceptions, reductions, or limitations on coverage;
- The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
- Template language in the “Why it Matters” section;
- Uniform definitions;
- The renewability and continuation of coverage provisions;
- Coverage examples (common benefits scenarios for having a baby (normal delivery) or managing Type 2 diabetes (routine maintenance, well-controlled);
- A statement that the SBC is only a summary and that the plan document, policy or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage;
- A contact number to call with 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;
- An Internet address (or other contact information) for obtaining a list of the network providers, an Internet address where an individual may find more information about the prescription drug coverage under the plan or coverage, and an Internet address where an individual may review the Uniform Glossary, and a disclosure that paper copies of the Uniform Glossary are available; and
- A uniform format, four double-sided pages in length, and 12-point font.

univera HEALTHCARE an excellus company

QUESTION & ANSWER

Q: When will Univera Healthcare begin sending SBCs to the employer groups?

A: According to the regulations SBCs must be provided to employer groups and members *beginning* 9/23/12. Legal clarification of *beginning* means the following:

- SBCs must be provided to new employer groups and direct pay individuals looking to enroll on or after 9/23/2012
- SBCs must be provided to existing employer groups, group members, and direct pay enrollees upon their first renewal on or after 9/23/2012.
- SBCs must be provided within 7 days upon request beginning 9/23/2012.

Q: When will SBCs be created for each employer **group?**

A: The goal is to create the SBCs with each rate quote beginning 9/23/12.

- The SBCs will be submitted to Sales with each experience rated quote via Quote Tracker (QT).
- For community rated quotes the SBCs will be in Blue On Demand (BOD).

Q: Does Univera Healthcare anticipate 100% compliance in completing and issuing the SBCs within the first year?

A: Univera Healthcare is striving to be in compliance. Due to system and resource constraints an iterative solution is being put in place. Therefore, every SBC may not be created and distributed within the first year. Univera will work with any group to show the government that good faith effort has been put forth; therefore, no penalties will be assessed.

Q: Will Univera Healthcare create SBCs for self-funded groups?

A: Yes. The SBC will be submitted to Sales with each rate quote via Quote Tracker. If the product is custom, Sales will need to give the Stepwise team the detailed product benefit information.

Q: Will there be a charge for creating the SBCs for self-funded groups

A: No.

Q: Will Univera Healthcare mass mail SBCs to members of an employer group?

A: No, the employer group will be responsible to distribute the SBCs to their members.

Q: Will Chambers, Trusts and Associations (CTAs) be required to distribute SBCs to member firms and their employees?

A: Yes. CTAs will be required to distribute SBCs to member firms and they will require member firms to distribute SBCs to their members.

Q: What will it show on the SBC if there is no medical benefit?

A: The SBC will show “Not covered.”

Q: What format is the SBC?

A: The SBC will be a PDF in the required format. The automated solution only produces PDFs; therefore, no other format will be available.

Q: What happens if an employer group does not have their drug and/or behavior health insurance with Univera Healthcare?

A: From 9/23/12 until 1/1/14, employer groups will be allowed to distribute more than one partial SBC to their members. The employer group will be responsible to create or obtain the SBC from the other insurer for the benefits that are not administered through Univera Healthcare.

Q: Will Univera Healthcare combine the SBCs for the employer groups that have drug and/or behavior health benefits with another insurer?

A: For the 1/1/14 deadline, Univera Healthcare is willing to assist the employer groups at a cost to be determined.

Q: When must an employer group provide an SBC to their members?

A: The employer group must provide the SBC(s) and any application materials to each participant no later than the first day the participant is eligible to enroll in coverage. The employer group must provide the SBC(s) and any renewal application materials must be provided to a renewing participant no later than 30 days prior to the first day of the new coverage period. The employer group must provide the SBS(s) within 7 days upon request from member.

Q: Are there any penalties for failing to provide a SBC and Uniform Glossary?

A: Employer groups and health plans are subject to a fine if they do not comply with the SBC regulation. The fines will be waived the first year, if good faith effort can be demonstrated.

Q: When must a health plan provide notice of a benefit change that is not reflected in the SBC?

A: If a health plan makes a material modification to coverage that would affect the content of the current SBC, the plan must provide notice of the change to enrollees no later than 60 days prior to the effective date of the change. The foregoing notice requirement does not apply to changes that occur in connection with the renewal of coverage.

Q: How do employer groups or members obtain copies of the Uniform Glossary?

A: The Uniform Glossary can be found at www.cciio.cms.gov

Q: What products are excluded from the SBC requirement?

A: Medicaid, Family Health Plus, Child Health Plus, Medicare Advantage, Medicare Supplemental, stand-alone dental and stand-alone vision products are excluded from the SBC requirement.

Q: **Will the SBC be created for closed, no longer promoted, or soon to be discontinued products?**

A: The SBC will be created by 9/23/1**3** for products that are closed, no longer promoted, and those that will not be discontinued on 1/1/2013. The SBC will not be created for products that are being discontinued 1/1/2013.

.

GLOSSARY

Health Plan
– An insurance organization that offers health insurance products and services to the public.

Employer Group
– A legally formed, sole proprietorship, partnership or corporation that is qualified to offer health insurance coverage to employees.

Subscriber
– The member of a group to whom the health insurance certificate is issued.

Dependent
– Any member approved to receive coverage under a subscribers health insurance contract.

Individual
– Any person either interested in buying or has purchased health insurance products or services directly from a health plan.

Uniform Glossary
– The uniform glossary is a common set of definitions and medical terms designed to help consumers understand and compare benefits.

Material Modification
– Any benefit change that changes the benefit coverage and contract between the health plan and subscriber.

ERISA
– The Employee Retirement Income Security Act of 1974, or ERISA, protects the assets of millions of Americans so that funds placed in retirement plans during their working lives will be there when they retire.