

Summary of Benefits and Coverage and the Uniform Glossary

Effective Date

- **For disclosures to members of group health plans** – For delivery to members of group plans with open enrollment periods, effective the first day of the first open enrollment period beginning on or after Sept. 23, 2012; for delivery to members that enroll other than through an open enrollment period (including special enrollees), effective the first day of the first plan year on or after Sept. 23, 2012.
- **For disclosures by issuers to group health plans** – Effective on or after Sept. 23, 2012.
- **For disclosures in the individual market** – Effective on Sept. 23, 2012.

The Departments of Health and Human Services (HHS), Labor and Treasury (the Agencies) issued final regulations on Feb. 9, 2012, regarding the Summary of Benefits and Coverage (SBC) and the Uniform Glossary for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act (the Act). The SBC final rule implements the disclosure requirements under section 2715 of the Public Health Service Act to help plans and individuals better understand their health coverage and easily compare coverage options across different types of plans and insurance products.

An SBC must be provided 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 or reissuance, and upon request.

The Act and the Final Rule requires that an SBC be provided to applicants, enrollees, and policyholders or certificate holders. The Act and Final Rule place responsibility to provide the SBC on:

- **For delivery to an insured group health plan:** The issuer.
- **For delivery to members of insured group plans:** The health insurance issuer and the group health plan including the plan administrator as defined by ERISA.

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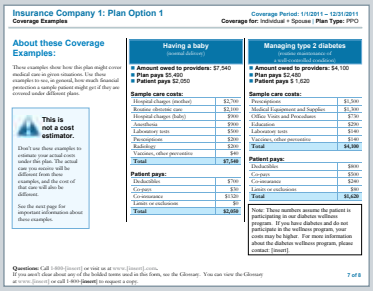
- **For delivery to members of self-insured plans:** The group health plan or designated administrator of the plan as that term is defined under ERISA. The Final Rule does not include an exemption for large or self-insured plans.

Content Requirements

The SBC must include the following standards using an approved template. The template was developed by the National Association of Insurance Commissioners (NAIC).

- A description of the coverage (including the cost-sharing, for each category of benefits identified by the Departments).
- The exceptions, reductions, or limitations on coverage.
- The cost sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations.
- The renewability and continuation of coverage provisions.
- A coverage facts label or 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.
- A uniform format, four double-sided pages in length, and 12-point font.

Coverage Examples


Insurance Company 1: Plan Option 1
Coverage Examples
Coverage Period: 1/1/2011 – 12/31/2011
Coverage for: Individual + Spouse | Plan Type: PPO
About these Coverage Examples:
This is not a cost estimator.
Having a baby (normal delivery)
Amount owed to providers: $7,540
Plan pays $5,490
Patient pays $2,050
Sample care costs:
Hospital charges (mother) $2,700
Routine obstetric care $2,100
Hospital charges (baby) $900
Anesthesia $900
Laboratory tests $300
Prescriptions $200
Radiology $300
Vaccines, other preventive $40
Total $7,540
Patient pays:
Deductibles $700
Copays $30
Co-insurance $1,320
Limits or exclusions $0
Total $2,050
Managing type 2 diabetes (routine maintenance of a well-controlled condition)
Amount owed to providers: $4,100
Plan pays $2,480
Patient pays $1,620
Sample care costs:
Prescriptions $1,500
Medical Equipment and Supplies $1,300
Office Visits and Procedures $730
Education $200
Laboratory tests $140
Vaccines, other preventive $140
Total $4,100
Patient pays:
Deductibles $800
Co-pays $500
Co-insurance $240
Limits or exclusions $80
Total $1,620
Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [insert].
Questions: Call 1-800-[insert] or visit us at www.[insert].com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.
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SBC Provided by Issuer to a Plan

The Final Rule requires a health insurance issuer to provide an SBC to an insured group health plan upon an application by the plan for coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. If there is any change to the information required to be in the SBC before the first day of coverage, the issuer must update and provide a current SBC to the plan no later than the first day of

coverage. The SBC must be provided upon request, as soon as practicable, but in no event later than seven business days. The SBC must be provided upon renewal as follows:

- **Renewal when a reapplication is required:** The proposed rule required that, if written application materials are required for renewal, the SBC must be provided no later than the date on which the materials are distributed. This requirement has been retained without change in the Final Rule.
- **Automatic renewal:** The Final Rule requires that, in general, if renewal or reissuance of coverage does not require reapplication, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year. With respect to insured coverage, the Final Rule provides flexibility with the 30-day rule when the terms of coverage are finalized in fewer than 30 days in advance of the new policy year (e.g., negotiation of coverage terms).

SBC Provided by Plan and/or Issuer to Participants and Beneficiaries

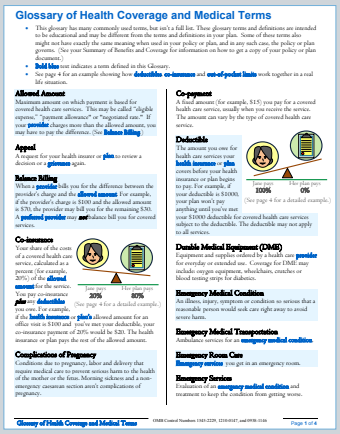
The Final Rule requires the issuer (for insured membership) and the group health plan to provide an SBC to participants and beneficiaries as part of written application materials or no later than the first date on which the participant is eligible to enroll if an application is not required. If there is any change to the information required to be 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, as described above. The Final Rule provides that "special enrollees" under HIPAA must be provided the SBC no later than when a summary plan description is required to be provided under the timeframe set by ERISA, which is 90 days from enrollment.

The Final Rule retains the requirement that the SBC be provided to both participants and beneficiaries, however it retains an anti-duplication rule under which a single SBC may be provided to a family unless any beneficiaries are known to reside at a different address.

Uniform Glossary

The Uniform Glossary includes many commonly used health coverage and medical terms, but isn't a full list. These terms and definitions are intended to be educational and may be different from the terms and definitions for a plan. Some of these terms might not have exactly the same meaning when used in a policy or plan, and in any such case, the policy or plan governs. The glossary may not be modified by plans or issuers. Plans and issuers must also provide a paper copy of the Uniform Glossary upon request.

Uniform Glossary


Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetes.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Glossary of Health Coverage and Medical Terms — OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 — Page 1 of 4

Culturally and Linguistically Appropriate

The final rule retains the requirement to provide the SBC in a culturally and linguistically appropriate manner. A plan or issuer follows the rules for providing notices with respect to claims and appeals to satisfy this requirement. Under those rules, plans and issuers must provide notices in a culturally and linguistically appropriate manner when 10 percent or more of the population residing in the claimant's county are literate only in the same non-English language, as determined based on American Community Survey data published by the U.S. Census Bureau.

Notice of Modification

The Act directs that a group health plan or insurance issuers (group or individual) provide notice of a material modification of coverage (as defined under ERISA section 102), at least 60 days, in advance, if any of the changes in coverage are not reflected in the most recently provided SBC. The notice must be provided to enrollees (or, in the individual market, policyholders) no later than 60 days prior to the date on which such change will become effective, if it is not reflected in the most recent SBC provided, and occurs other than in connection with a renewal or reissuance of coverage.

The Final Rule does not change the proposed rule's 60-day notice provision. This provision requires that plans and issuers provide at least 60 days', advance notice of any material modification that would change the content of the SBC. This applies to mid-year changes only and does not affect changes made in connection with a renewal or reissuance. The notice of modification may consist of a new SBC or a specific notice detailing the change.

Penalty for Failure to Provide the SBC

A group health plan (including its administrator), and a health insurance issuer offering group or individual health insurance coverage, that willfully fails to provide required information will be subject to a fine of not more than $1,000 for each such failure. Each failure to deliver the SBC to an individual constitutes a separate offense under the Act.

For more information
You may visit us at uhc.com/reform or discuss with your account team.

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