HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

SBC Employer Guide

If you have questions at any time, contact your Sales Account Executive.

An Employers' Guide to The Summary of Benefits and Coverage (SBC)

Overview

Make sure you comply!

Willful failure to deliver your SBC to members within the required time frame may result in a **fine of $1,000 per each covered individual!**

The Summary of Benefits and Coverage (SBC) establishes standards that group health plan sponsors and insurers must use when offering group or individual health insurance. It was created by the Departments of Health and Human Services, Labor, and the Treasury (the departments). The SBC's purpose is to accurately describe the benefits and coverage under the group plan.

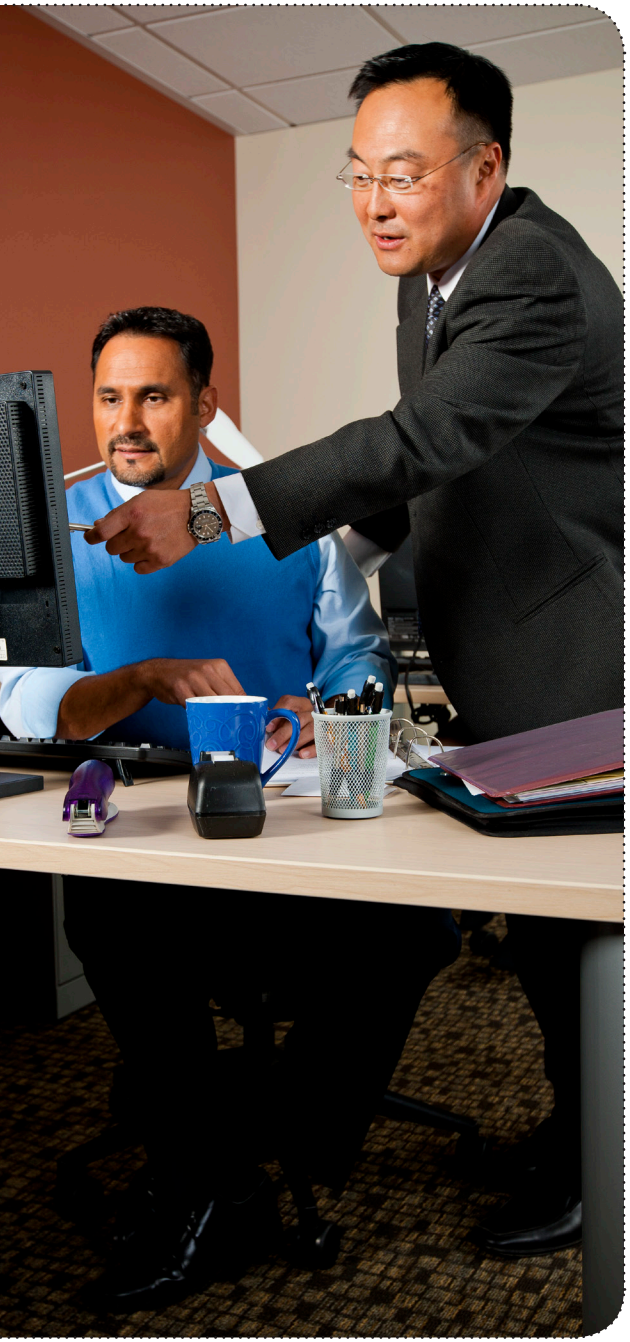
Why the SBC requirement was created

Among other things, the standards were created to ensure that benefits and coverage information is presented in a clear and uniform format that helps plans and individuals better understand their health coverage and compare coverage options across different types of plans and insurance products.

The SBC was developed under section 2715 of the Public Health Service Act (PHS Act) as added by the Patient Protection and Affordable Care Act (Affordable Care Act).

What the SBC document includes

The departments consulted with the National Association of Insurance Commissioners (NAIC) to develop standards for providing SBCs.



The SBC must include:

- 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
- Appeals/Grievance Rights
- Coverage examples, including 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 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

Key Date: Sept. 23, 2012

The effective date for providing applicants, enrollees, and policyholders or certificate holders an SBC is on or after Sept. 23, 2012.

Enrollment during open enrollment period

The requirements to provide an SBC, notice of material modification and Uniform Glossary apply for disclosures to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period beginning on the first day of the first open enrollment period that begins on or after Sept. 23, 2012.

Enrollment other than open enrollment

For SBC distributions to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (example, special enrollees, new hires), the requirements apply beginning the first day of the first plan year that begins on or after Sept. 23, 2012.

Other SBC distributions

For SBC distributions to group health plans by an insurer, these requirements are applicable beginning on Sept. 23, 2012.

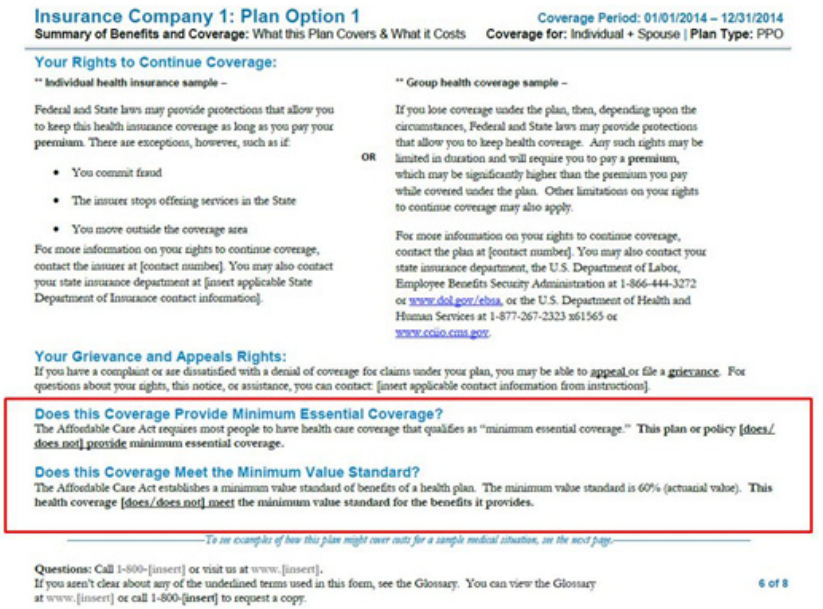
Fully Insured Plans

SBCs for group health plans beginning on or after January 1, 2014 will include a statement detailing whether the plan meets minimum essential coverage (MEC) and minimum value (MV) (60 percent of the costs of benefits for a population). For HPN/SHL created SBCs, we will support group health plans with determining whether their 2014 plan coverage meets the MV requirements for the HPN/SHL services that we provide.

On page six of the sample completed SBC template (Authorized for second year of applicability), a plan or issuer should indicate in the designated area on the SBC template that the plan or coverage "does" or "does not" provide MEC and whether the plan or coverage "does" or "does not" meet applicable MV requirements. There are no changes to the Uniform Glossary, the Instructions for Completing the SBC, "Why This Matters" language for the SBC, or to the coverage examples.

In addition to these changes to the SBC template, the agencies extended many enforcement relief provisions through 2014 that were originally set to expire in 2013. This includes the enforcement relief for:

- Extension for use of the HHS coverage calculator for the coverage examples
- Enforcement relief for plans and issuers that are working diligently and in good faith to come into compliance
- Employers who have carve out benefits can continue to use a second SBC
- No additional coverage examples



Insurance Company 1: Plan Option 1 Coverage Period: 01/01/2014 – 12/31/2014
Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Spouse | **Plan Type:** PPO

Your Rights to Continue Coverage:

** Individual health insurance sample –

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at [contact number]. You may also contact your state insurance department at [insert applicable State Department of Insurance contact information].

OR

** Group health coverage sample –

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions].

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy [does/does not] provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage [does/does not] meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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.

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What HPN/SHL will do for Fully Insured Plans

For insured health plans, Health Plan of Nevada (HPN) and Sierra Health and Life (SHL) and the Group Health Plan are jointly responsible for meeting the SBC requirements for creation and delivery of the SBCs to members.

HPN/SHL will:

- Create your entire SBC for the services that you insure through HPN/SHL
- Put it in the uniform format outlined by the Affordable Care Act and its implementing regulations,
- Calculate and include the coverage examples in your SBC,
- The SBC will be available on @YourService, or delivered to you via direct mail or in person.
- Distribute the SBC to your employees via direct mail.
  Note: In the pre-enrollment situation, HPN/SHL will not know the identities of eligible but unenrolled members so we anticipate relying upon our employer customers, or broker acting on their behalf, to deliver the SBCs to new hires mid-year, and at open enrollment.
- Update the entire SBC, going forward, whenever you request a benefit change.

If you utilize external vendors for certain benefits, there could be additional tasks or SBCs that are required:

Partial SBC Creation (Excluding external vendors)

If HPN/SHL provides your medical insurance coverage but you use external vendors for other benefit services, we will create the SBC, including calculating coverage examples, for the services that you insure through HPN/SHL. You will be responsible for completing any information from outside vendors and completing the calculation of the coverage examples within the SBC document.

Plans excluded from the SBC requirements include:

- Retiree-only
- Stand-alone dental or vision

What HPN/SHL will do for Fully Insured Plans

Deadlines

Timing is everything when it comes to properly completing your SBC.

Group Health Plan SBC

A health insurance issuer that offers group health insurance must provide an SBC to the plan or plan sponsor:

- Within seven (7) business days after receipt of an application for health coverage;
- By the first day of coverage, if there are any changes to the initial SBC;
- If written application for renewal is required, no later than the date the written application materials are distributed;
- If written application is not required for renewal, the later of 30 days before the beginning of the new plan or policy year or within seven (7) business days of receiving the group's intent to renew; and
- After Sept. 23, 2012, within (7) seven business days after receipt of a request from the plan or plan sponsor.

Member/Employee SBC

The plan administrator or health insurance issuer (for insured plans) must provide an SBC to a member:

- As part of the written application or enrollment materials (i.e., new hire enrollment packet). If the plan does not distribute written enrollment materials, the SBC must be distributed no later than the first date on which the employee is eligible to enroll for coverage;
- By the first day of coverage, if there are any changes to the initial SBC;
- Within 90 days from enrollment for any special enrollee. A special enrollee is generally an employee who enrolls mid-year upon the occurrence of a special enrollment event, such as marriage, birth of a child, or loss of other coverage;
- For renewal, if the member must actively elect to maintain coverage, or has the opportunity to change coverage options during an annual open enrollment period, an SBC must be distributed as part of the open enrollment materials;
- If written application is not required for renewal, the later of 30 days before the beginning of the new plan or policy year or within seven (7) business days of receiving the group's intent to renew; and
- Within seven (7) business days after receipt of request by the member.

The following three pages provide a breakdown of the three main times changes may be made to your SBC.

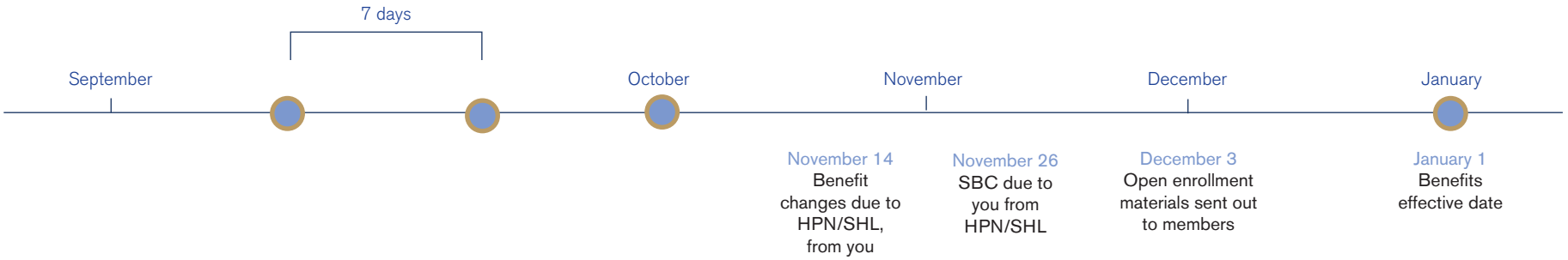
What HPN/SHL will do for Fully Insured Plans

At renewal

The timelines associated with changes at renewal are dependent upon whether the SBC update involves open enrollment or any actual benefit changes:

- **Benefit change with open enrollment**
  HPN/SHL will provide the completed SBC electronically to you in advance of the date open enrollment materials are distributed as long as we receive notification of benefit changes at least seven (7) business days before we are required to deliver the SBC to you.
- **Benefit change with no open enrollment**
  HPN/SHL will provide the completed SBC to you prior to the effective date of the plan as long as we receive notification of benefit changes at least (7) seven business days before we are required to deliver the SBC to you.
- **No benefit change**
  If there are no changes to your current SBC, the existing SBC will be updated to reflect the new coverage period and provided to you within the time frames stated above.

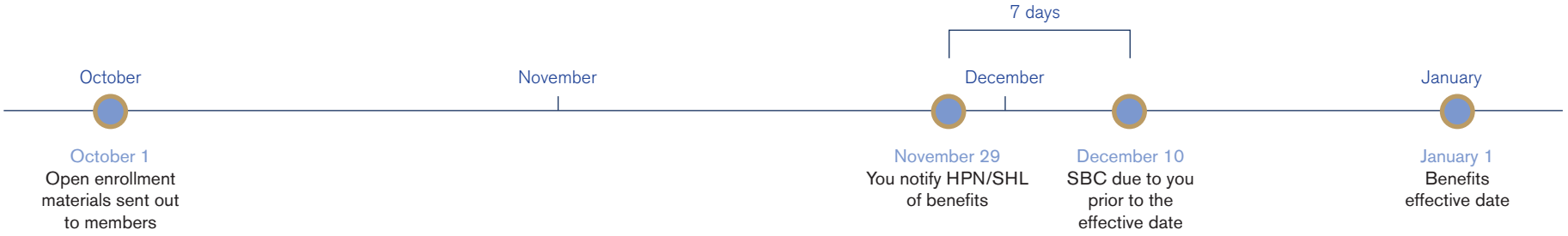
Sample timeline with open enrollment



Prior to renewal (changes between open enrollment and renewal)

If you have changes prior to renewal, but after distribution of the first SBC, HPN/SHL will provide you the completed SBC by the first day of coverage as long as we receive notification of benefit change at least seven (7) business days before the first day of coverage.

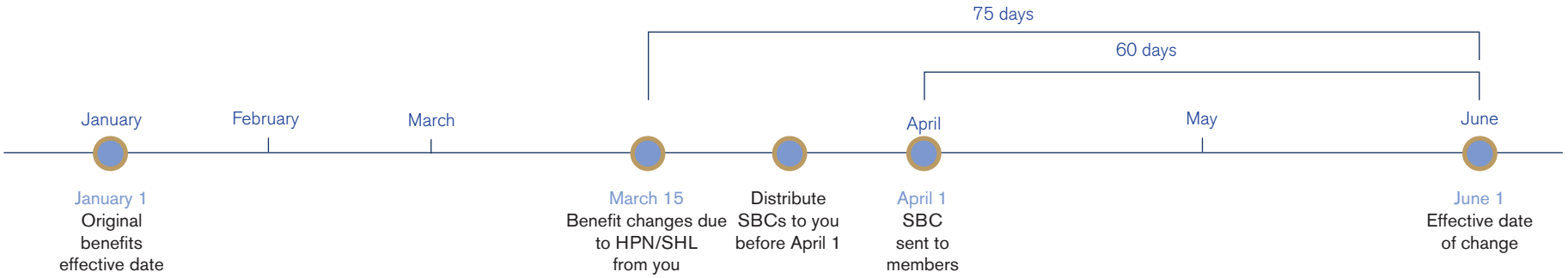
Sample timeline



Off-cycle plan change

HPN/SHL will provide you the completed SBC electronically in advance of the effective date of the change as long as we receive notification of benefit changes 75 business days in advance from you as an existing customer. Revised SBCs are required to be provided to members 60 days in advance of the change.

Sample timeline



Translation of SBCs

Final regulations require that the SBC be provided in a culturally and linguistically appropriate (CLA) manner. The CLA provision applies only to counties identified in the American Community Survey data provided by the U.S. Census Bureau report to have 10 percent or more of the population being literate only in the same non-English language.

HPN/SHL will provide members with translation services at no additional cost. For oral translation services, we will follow the business model and utilize a vendor to facilitate where needed. Written translation will be provided, upon request, for the languages required by the CLA provision.

The languages currently required are:

- Spanish
- Chinese
- Tagalog
- Navajo

To help plans and issuers meet the language requirements, HHS will provide written translation of the SBC template, sample language and Uniform Glossary.

How you may provide it

Your SBC may be provided in paper form, by email or by posting it on your company Intranet.

Electronic transmission requirements

Electronic delivery for enrolled members is subject to Department of Labor (DOL) regulations on electronic disclosure. For more details about the DOL electronic disclosure requirements, login to @YourService.

Your SBC can be provided electronically to members who are eligible for, but not enrolled in, coverage if the following conditions are met:

1) The format is readily accessible
2) A paper copy is provided free of charge upon request
3) If your company Intranet posting is used, an email or paper form notification must be sent to the employee stating the SBC is available on the Intranet.*

*The notification must provide your Intranet address and tell the member the document is available in paper form upon request.

SBC Template (Authorized for first year of applicability)

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 *specific* 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].
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OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

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

Your Rights to Continue Coverage:

**** Individual health insurance sample –**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at [contact number]. You may also contact your state insurance department at [insert applicable State Department of Insurance contact information].

OR

**** Group health coverage sample –**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions].

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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To view SBC Templates, go to http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html#Summary of Benefits and Coverage and Uniform Glossary

SBC Template (Authorized for second year of applicability)

Insurance Company 1: Plan Option 1 **Coverage Period: 01/01/2014 – 12/31/2014**
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OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 23, 2013 (corrected)

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