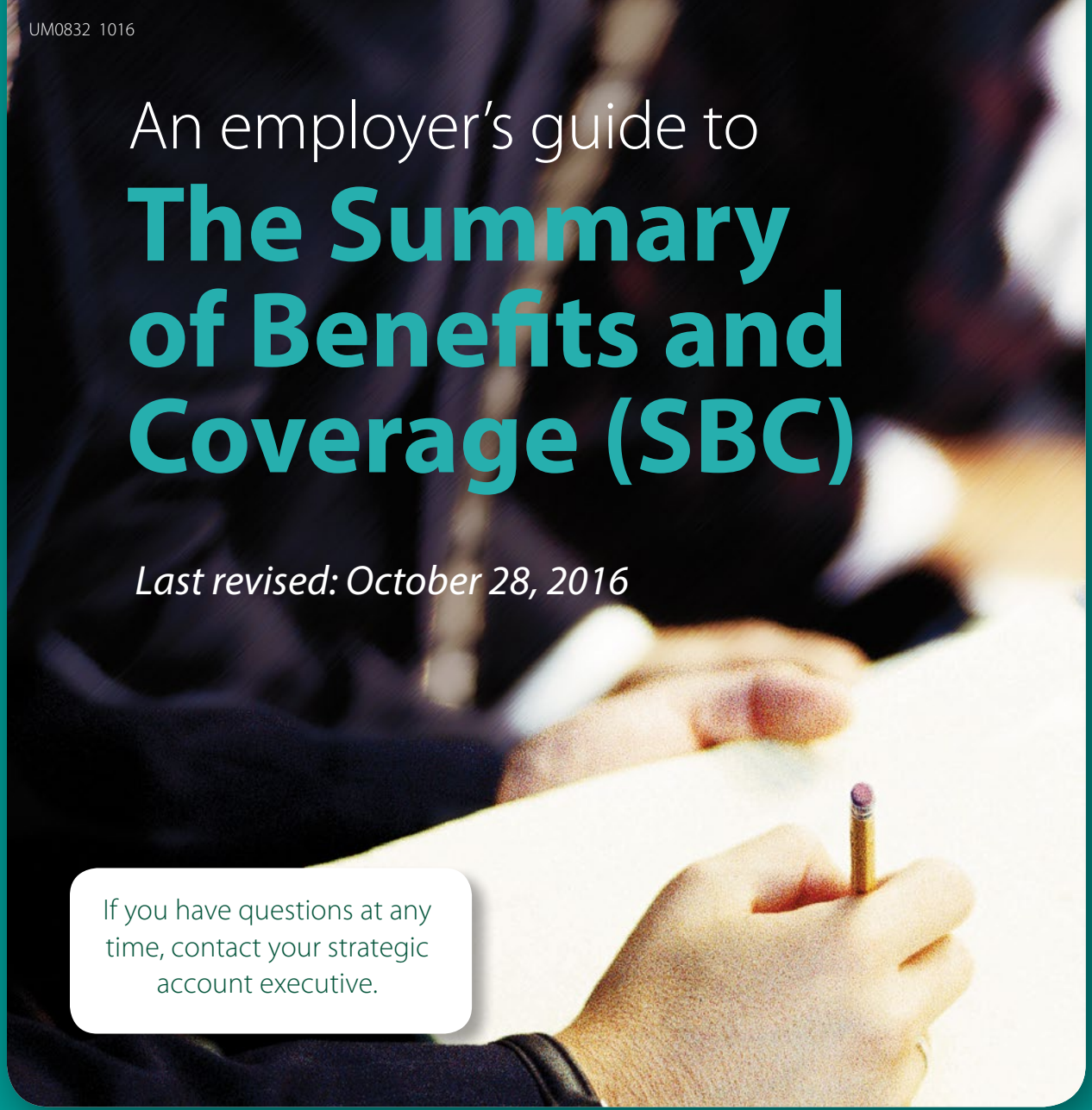
UM0832 1016

Exit

An employer's guide to

The Summary of Benefits and Coverage (SBC)

Last revised: October 28, 2016



If you have questions at any time, contact your strategic account executive.

UMR℠

A UnitedHealthcare Company

Click on the tabs below to learn more about the process for completing your SBC.

Overview | What UMR will do | What you need to do | Other resources

Overview

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 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 clear language and in a consistent format to help consumers better understand their coverage and more easily compare coverage options.

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.

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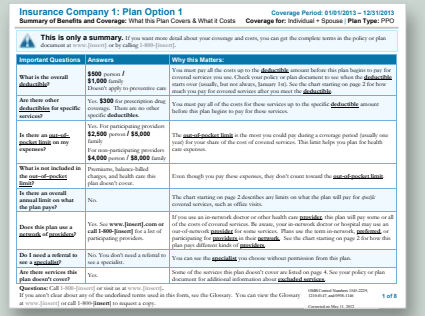
Overview



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].
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
1 of 8
Corrected on May 11, 2012

SBC example:
Click on the thumbnail above to see a sample SBC.

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 co-payment obligations
- The renewability and continuation of coverage provisions
- Appeals/Grievance Rights
- A coverage facts label or coverage examples, including common benefit scenarios for having a baby (normal delivery), managing Type 2 diabetes (routine maintenance, well-controlled), and simple foot fracture.
- 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

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Overview

Key Date: April 1, 2017

The effective date for providing applicants, enrollees and policyholders or certificate holders and updated SBC is April 1, 2017.

Enrollment during open enrollment period

The requirements to provide an SBC, notice of 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 April 1, 2017.

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 April 1, 2017.

Other SBC distributions

For SBC distributions to group health plans by an insurer, these requirements are applicable beginning on April 1, 2017.

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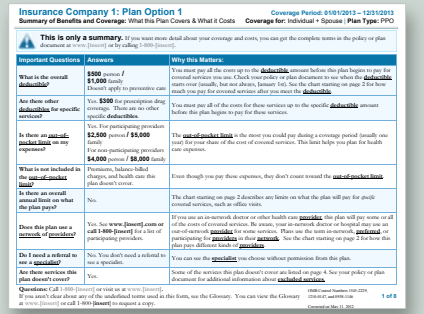
What UMR will do



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

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Important Questions	Answers	Why this Matters:
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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.
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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.
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SBC example:
Click on the thumbnail above to see a sample SBC.

Please note that as the plan sponsor, you are responsible for meeting the SBC requirements.

UMR will help you create your SBC, including calculating coverage examples, and deliver it to you for distribution via your online employer portal. We'll put it in the uniform format outlined by PPACA and its implementing regulations.

The cost to create and post the electronic SBC to the Web portal is included in UMR's medical administration fee.

The SBC is a separate document which includes all coverage tiers (e.g. individual and family) for each medical plan.

Click on the buttons below to find out more.

Service offerings | Deadlines | Translation of SBCs

What UMR will do

Plans excluded from the SBC requirements include:

- *Retiree-only*
- *Stand-alone dental or vision*
- *Stand-alone behavioral health*

Service offerings

Please note that you must use UMR as your medical administrator in order for us to help you with your SBC.

UMR offers two ways to help you:

- **Full SBC Creation (No external vendors)**
  We can create your entire initial SBC if you use no other vendors other than UMR or one of our sister companies, for benefit services. We will include OptumRx or UnitedHealthcare Pharmacy, if appropriate.

  UMR will also update the entire SBC going forward whenever you request a benefit change as long as you continue to use no external vendors.

- **Partial SBC Creation (External vendors)**
  If UMR provides your medical administration but you use external vendors for other benefits services, we will create the SBC for only the services that you receive from UMR.

  You will be responsible for completing any information from outside vendors and completing the calculation of the coverage examples within the SBC document.

  UMR can only make requested benefit change updates to the SBC going forward for the services that we provide you.

What UMR will do main page

What UMR will do

Steps UMR takes to produce an SBC

Producing an SBC requires several steps in the administrative process:

- *The first step is installing all necessary coding changes*
- *Once installed, a very thorough quality review is conducted to ensure the accuracy of the changes*
- *After a successful installation, the SBC is generated*
- *Another thorough quality review is conducted to ensure the SBC is accurate*
- *The final step is posting the SBC to your customer Web portal*

Deadlines

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

For example, a change to your benefit plan off your normal renewal date may require you to submit your benefit change(s) to UMR almost six months in advance of the effective date of the change!

Here is a breakdown of the three main times when changes may be made to your SBC.

At renewal | Prior to renewal | Off renewal

What UMR will do main page

What UMR will do

At renewal

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

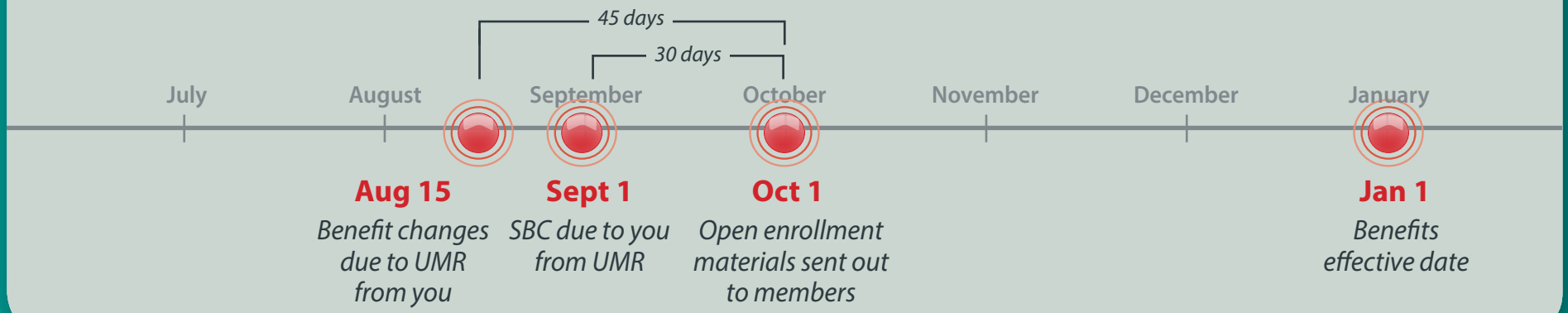
- **Benefit change with open enrollment**
  UMR will provide the completed SBC electronically to you in advance of the date open enrollment materials are distributed. This is provided we receive notification of benefit changes 45 calendar days before the SBC is required to be distributed.

- **Benefit change with no open enrollment**
  UMR will provide the completed SBC electronically to you prior to the effective date of the plan. This is provided we receive notification of benefit changes 45 calendar days before the SBC is required to be distributed.

- **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 electronically within the time frames stated above.

Deadlines main page

Sample timeline with open enrollment



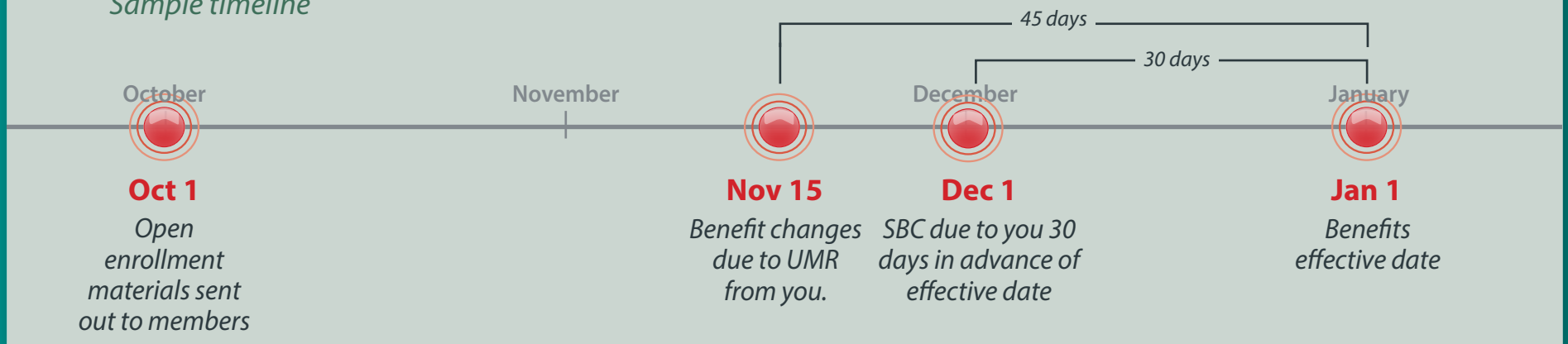
What UMR will do

Prior to renewal (changes between open enrollment and renewal)

If you have changes prior to renewal but after distribution of the first SBC, UMR will provide you the completed SBC electronically in advance of the first day of coverage. This is provided we received notification of benefit changes at least 45 calendar days before the SBC is required to be distributed.

Deadlines main page

Sample timeline



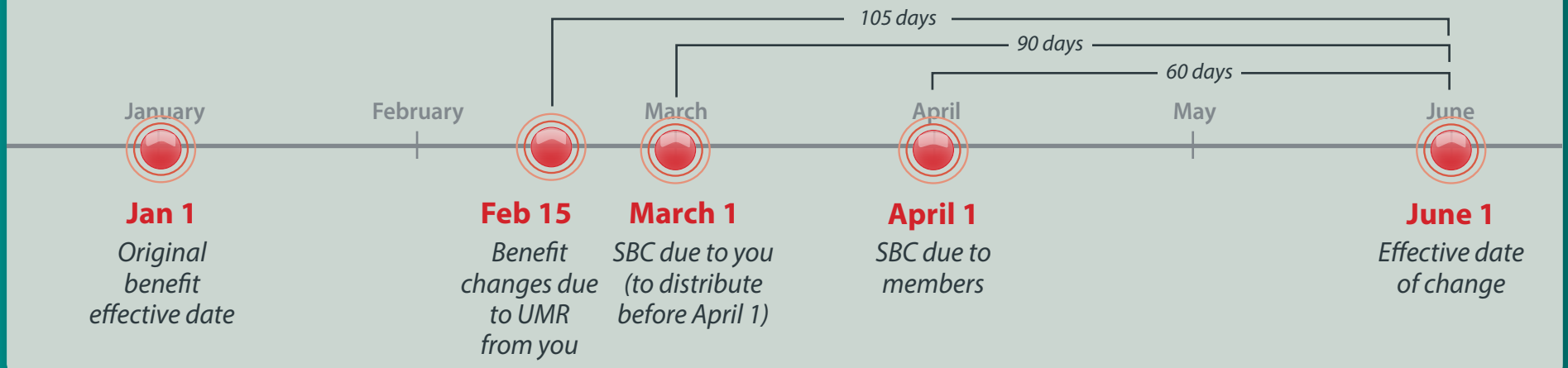
What UMR will do

Off renewal

You are required to provide your SBC to your members 60 days in advance of the benefit effective date. UMR will provide you the completed SBC electronically prior to the required 60-day advance notification period. This is provided we received notification of benefit changes 45 days before the SBC is required to be distributed.

Deadlines main page

Sample timeline



What UMR will do

American Community Survey (ACS) data

The SBC translation is the same as the current appeals translation requirements. Click here to determine if your group has any employees in the required counties.

Translation of SBCs

UMR will coordinate translation of the fully completed SBC upon request to meet the culturally and linguistically appropriate (CLA) language provision. 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.

The four languages currently identified are:

- Spanish
- Chinese
- Tagalog
- Navajo

You will need to complete all information on your SBC (phone number, Web address, external vendor information, etc.) before UMR will coordinate the translation. It is recommended that you also anticipate what document(s) will need to be translated and request the translation in advance.

UMR will provide the translated SBC 21 business days after receiving the approved final SBC from you.

What UMR will do main page

What you need to do

Did you know?

As a group health plan sponsor, you must provide the Uniform Glossary in the format required by the Departments. This is to ensure the information is consistent and uses language that the average plan enrollee can understand.

UMR will provide a link within your employer Web portal to the DOL and CMS Web site so you may print copies for your employees. UMR will refer the member back to you for a paper copy of the uniform glossary.

View Uniform Glossary

As a plan sponsor, you are responsible for creating and distributing the SBC.

As your medical administrator, UMR can help you create it. However, you must still distribute the document to your plan members.

Following is a detailed breakdown of who gets your SBC and when. We have also included details on how you may provide it to your plan members along with information on:

- How you can initially access your SBC once UMR has completed our portion
- How to submit your SBC once you have finalized it

Who gets your SBC

When do they get it

How you may provide it

Accessing and finalizing your SBC

What you need to do

Who gets your SBC

Your SBC must be provided to both eligible members and their dependents. For new enrollees, an SBC needs to be provided for each plan the member is eligible to be enrolled in. For members currently enrolled in a plan, only the SBC for the plan in which they are enrolled must be provided.

You can send a single SBC to an employee and his or her dependents if they are all living at the same address. However, if any beneficiaries live elsewhere, you need to be sure they also receive an SBC.

What you need to do main page

What you need to do

When do they get it

You must provide an SBC in these situations:

- At renewal
- Upon request
- Special enrollees
- Off renewal changes

- **At renewal**

  How and when SBCs should be provided at renewal depends on several factors:

  1) **When a reapplication is required**
     – *If written applications are required for renewal (paper or online), the SBC must be provided no later than the date on which the materials are distributed.*
     – *If the plan does not distribute written applications for enrollment, the SBC must be distributed no later than the first date a member is eligible to enroll in coverage.*

  2) **Automatic renewal**
     The SBC Final Rule states that, in general, if a renewal or reissuance of coverage does not require reapplication, the SBC must be provided no later than 30 calendar days prior to the first day of the new plan year.

  3) **SBC change**
     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.

Next

What you need to do

What is a material modification?

A material modification is any modification to the coverage offered under a plan that – independently or in conjunction with other modifications or changes – would be considered by an average plan participant or individual covered under a policy to be an important change in covered benefits or other terms of coverage under the plan or policy.

Important changes include:

- *Elimination of benefits*
- *Reduction of benefits under the plan, including formulas, methodologies or schedules that serve as the basis for making benefit determinations*
- *Increases in benefits under the plan*
- *Increases in deductibles, coinsurance, co-payments or other amounts to be paid by a participant or beneficiary*
- *Decreases in deductibles, coinsurance, co-payments or other amounts to be paid by a participant or beneficiary*
- *Changes in state mandates for non-ERISA plans that are contained within the SBC*
- *Establishment of new conditions or requirements (for example, preauthorization requirements) for obtaining benefits under the plan*

- **Upon request**
  If a request is received, the SBC should be provided as soon as possible, but never later than seven business days.

- **When you have "special enrollees"**
  A special enrollee is a plan member who has a HIPAA Special Enrollment event, such as a marriage or birth of a child, or loss of other coverage. An SBC must be provided no later than when a summary plan description is required under the time frame set forth in ERISA, which is 90 calendar days from enrollment.

- **Off renewal changes**
  A notice of material modification is required for a change that occurs other than in connection with a renewal. You must notify your members at least 60 calendar days in advance of the effective date of the change if the change affects information included in the SBC and is not reflected in the most recent SBC.

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What you need to do main page

Overview | What UMR will do | What you need to do | Other resources

What you need to do

How you may provide it

Your SBC may be provided in paper form, by e-mail or by posting it on the Internet.

Electronic transmission requirements

Electronic delivery for enrolled members is subject to Department of Labor regulations on electronic disclosure. For more details about the DOL electronic disclosure requirements (29 CFR 2520.104b-1(c)) please click here.

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

1) The format is readily accessible

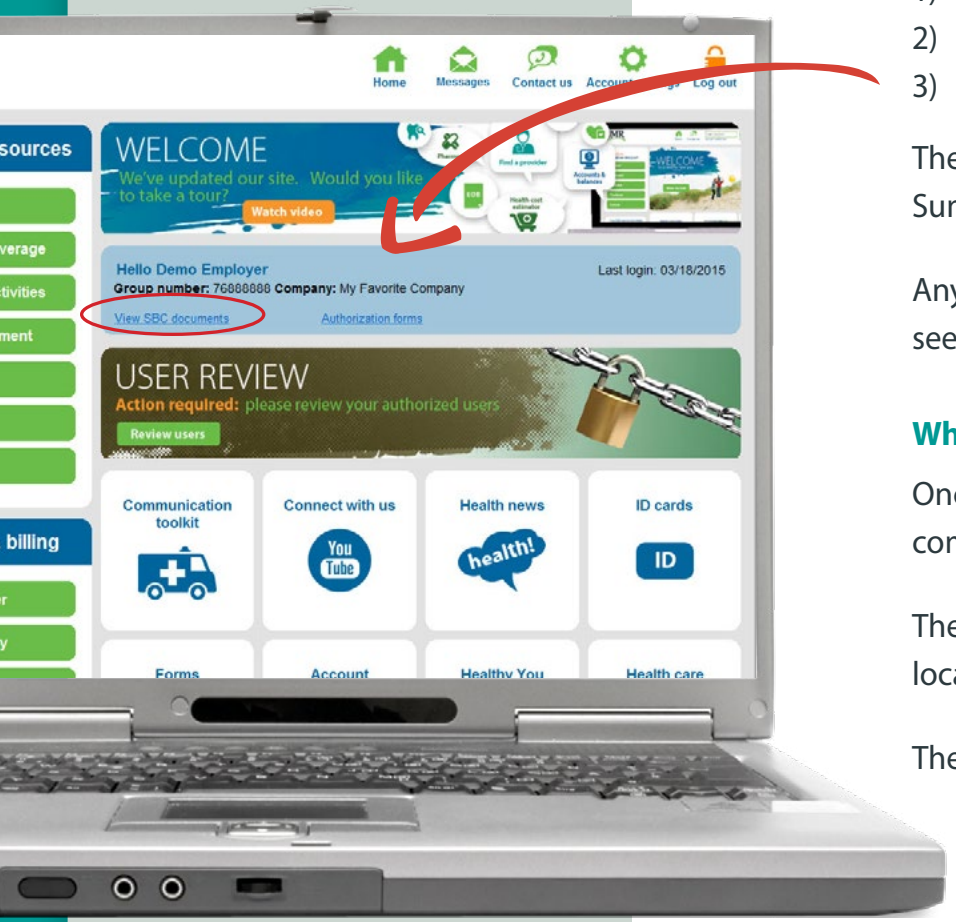
2) A paper copy is provided free of charge upon request, and

3) If an Internet posting is used, an e-mail or paper form notification must be sent to the employee stating the SBC is available on the Internet*

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

What you need to do main page

What you need to do



Accessing and finalizing your SBC

How to access your SBC

Once UMR has finished creating your SBC, we will post it on your UMR Web portal. You can access the file by:

1) Logging into the UMR Employer portal
2) Entering your username and password
3) Selecting View SBC documents

The file will be labeled UMRFinal in the Status column of the Summary of benefits & coverage documents location.

Any employee who is authorized with benefit inquiry will be able to see the SBC posted to the employer Web portal.

What to do when you have finished your SBC

Once you have finished your SBC, please attach a copy of the completed SBC in an e-mail to your UMR Strategic Account Executive.

The final approved version of the SBC will then be posted in the same location on your UMR Web portal.

The file will be labeled CustomerFinal in the Status column.

What you need to do main page

Other resources

To assist you in completing your SBC, we have included examples of a full SBC and a partial SBC. In each example, we have highlighted the areas you will need to complete depending upon which option applies to you.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2017-12/31/2017

Coverage for: Individual+Family | Plan Type: PPO

UMR: SAMPLE FULL SBC GROUP HEALTH PLAN BP 001

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.umr.com or call 1-800-826-9781. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.umr.com or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 person / $4,000 family in-network $2,500 person / $5,000 family out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	Yes. $2,500 person / $7,500 family in-network $3,500 person / $8,500 family out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Copayments for certain services, penalties, premiums, balance billing 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.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-826-9781 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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View sample

Full SBC

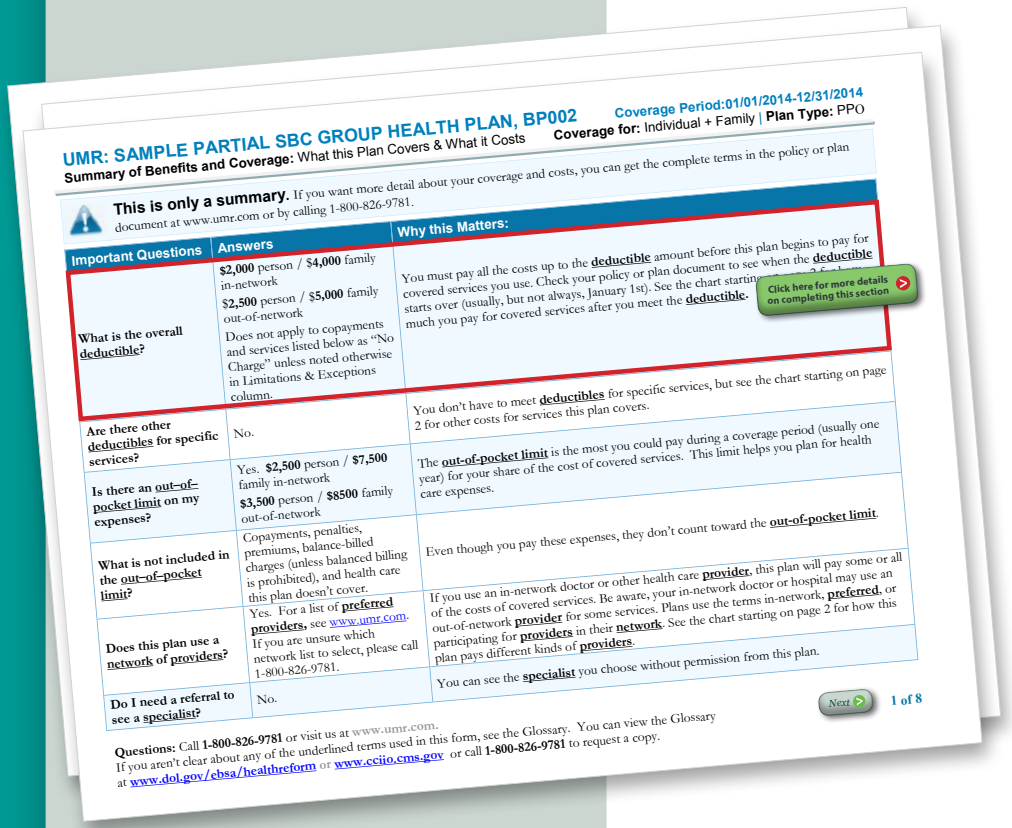
The full SBC requires only minimal activity on your part. UMR has completed a majority of the document since you use no external vendors other than UMR or one of our sister companies.

Your main responsibility is to complete the highlighted foreign language requirements section and review and approve the entire document.

Once you have completed those responsibilities, please e-mail your approved final SBC to your strategic account executive.

Next

Other resources



UMR: SAMPLE PARTIAL SBC GROUP HEALTH PLAN, BP002 Coverage Period:01/01/2014-12/31/2014
Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual + Family | Plan Type: PPO

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000 person / $4,000 family in-network $2,500 person / $5,000 family out-of-network Does not apply to copayments and services listed below as "No Charge" unless noted otherwise in Limitations & Exceptions column.	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?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. $2,500 person / $7,500 family in-network $3,500 person / $8500 family out-of-network	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?	Copayments, penalties, premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.umr.com. If you are unsure which network list to select, please call 1-800-826-9781.	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 terms 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 can see the specialist you choose without permission from this plan.

Click here for more details on completing this section

Questions: Call 1-800-826-9781 or visit us at www.umr.com. 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.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-826-9781 to request a copy.

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View sample

Partial SBC

The partial SBC requires some additional work on your part since you use external vendors besides UMR for other benefit services.

You will need to complete information in highlighted sections about:

- Deductibles
- Out-of-pocket limits
- Prescription drug coverage
- Foreign language requirements
- Dental and vision benefit information

More instructions about completing those sections are embedded in the actual SBC sample.

Once you have completed those sections, please review and approve the entire document. You can then e-mail your approved final SBC to your strategic account executive.

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Other resources

Helpful Web links

Here are several links to governmental Web sites you may find helpful in answering any questions you may have about the SBC process:


Final regulations


Compliance


Uniform Glossary

Instruction guide


Electronic delivery


American Community Survey (ACS) data

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