SUMMARY OF BENEFITS AND COVERAGE (SBC)

Overview

As a result of the Affordable Care Aca (ACA), beginning September 23, 2012 employers are required to provide a Summary of Benefits and Coverage (SBC) to employees.

The purpose of the SBC is to provide individuals with standard information so they can compare medical plans as they make decisions about which plan to choose.

Employers are to distribute the SBC at these times:

- When individuals enroll in coverage for the first time
- At the beginning of each new plan year/renewal
- Within seven business days, if an individual requests a copy

What information must be included in an SBC

An SBC must be created by inserting plan details into predetermined rows and columns using the exact wording, format and layout provided. Samples and instructions are available at the **Department of Labor website**.*

An SBC includes these components.

Four-page benefit summary	Four-pages (two-sided, eight pages maximum, 12-point font, in color or grayscale); can be included in another document, but must be placed prominently at the beginning.
Coverage examples	Estimated customer costs for two medical scenarios – having a baby and managing type 2 diabetes. The estimates are based on national average costs and in-network benefit levels under each plan.
Website and phone number	A prominently displayed website and phone number where individuals can get additional information.
Glossary	Definitions of common medical and insurance terms. The glossary must be provided on request and is posted on **www.healthcare.gov**.*

Overview of SBC requirements

Effective date	SBCs are required for all plan years or open enrollment periods beginning on or after September 23, 2012.
Types of plans affected	SBCs are required for: • Individual medical policies • Insured and self-insured group medical plans, regardless of grandfathered status SBCs are **not** required for: • U.S.-issued expatriate plans • Retiree-only plans • Medicare plans • Stand-alone dental and vision plans
Who is responsible for providing the SBC	• Individual plans: The insurance carrier • Insured employer plans: The Employer • Self-insured plans: The employer
SBC timing for employees	SBCs must be provided during each annual enrollment: • If an employee must enroll to continue coverage, the SBC must be provided when open enrollment materials are distributed. • If enrollment materials are not distributed, employees must receive an SBC by the first day they are eligible to enroll. • For insured plans, if coverage continues automatically for the next year, the SBC must be provided at least 30 days before the beginning of the new plan year. If the policy is not issued by that date, the SBC must be provided within seven business days once the information is available. • An individual must receive an SBC for the plan in which he or she is enrolled. SBCs for other available plans must be provided on request. • If any benefit changes are made between the time the SBC is provided and the coverage becomes effective, an updated SBC must be provided. The SBC must be provided within 90 days after an individual enrolls due to a special enrollment event. When an employee requests an SBC, it must be provided within seven business days.
Paper and electronic delivery of SBCs to employees	Information may be provided in either paper or electronic format. If an SBC is provided electronically to currently enrolled employees, the plan must comply with the ERISA rules for electronic delivery. For employees not yet enrolled, the SBC may be provided electronically by email or posted on the Internet. If posted on the Internet, the location must be prominent and readily accessible and individuals must be notified about where they can access the SBC and that a paper copy is available at no cost on request.
Language requirements	If a certain percentage of the population in a county speaks a language other than English, the availability of materials in the non-English language must be communicated by: • Including a notice of the availability of language assistance • Providing translation upon request in certain limited languages (currently Spanish, Traditional Chinese, Tagalog and Navajo)
Penalty for noncompliance	The penalty for willful noncompliance is up to $1,000 per enrollee for each failure to comply. Other ERISA and tax penalties may apply.
Who is responsible for paying any penalties	• Individual plans: The insurer • Insured employer plans: The employer • Self-insured plans: The employer

60-day notice for material modifications during the plan year

If any material change is made to a plan during the plan year that is not reflected in the most recent SBC, a notice must be provided at least 60 days before the effective date of the change.

A material change is any change that would be considered by an average participant to be an important enhancement or reduction in benefits. Changes made at annual renewal *do not* require 60-day advance notice.

How SBCS can be delivered to individual policyholders

An SBC may be provided in either paper or electronic format. It may be hand delivered or mailed. It may also be emailed or posted on the Internet after obtaining the individual's agreement to receive the SBC electronically.

If posted on the Internet, the individual must be notified about where the SBC is posted and that the SBC is available in paper form free of charge upon request. The electronic version must be in a format that is readily accessible, prominently displayed and in a format that can be electronically saved and printed.
Before receiving an application, an insurer can comply with the requirement to provide an SBC by posting the required information on the health care reform web portal available through **www.healthcare.gov**.*

BELOW IS A SAMPLE TEMPLATE OF SBC:

DAVIDOW FINANCIAL & INSURANCE SERVICES

20700 Ventura Blvd. • Suite 235 • Woodland Hills • CA 91364
(818) 264-1325 • (818) 264-1320 Fax • License# 0F56559

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?	$	
Are there other deductibles for specific services?	$	
Is there an out–of–pocket limit on my expenses?	$	
What is not included in the out–of–pocket limit?		
Is there an overall annual limit on what the plan pays?		
Does this plan use a network of providers?		
Do I need a referral to see a specialist?		
Are there services this plan doesn't cover?		

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness			
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need	Emergency room services			

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
immediate medical attention	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care			
	Delivery and all inpatient services			
If you need help recovering or have other special health needs	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	Eye exam			
	Glasses			
	Dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)
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Your Rights to Continue Coverage:

[insert applicable information from instructions]

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.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $
- **Patient pays** $

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	**$**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $
- **Patient pays** $

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	**$**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.