

Summary of Benefits and Coverage

Below are some of the most Frequently Asked Questions (FAQs) regarding implementation of the Summary of Benefits and Coverage (SBC) provisions of the Affordable Care Act.

Effective Date

When must plans and issuers begin providing the SBC?

For group health plan coverage, the regulations provide that, for disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including late enrollees and re-enrollees), the SBC must be provided beginning on the first day of the first open enrollment period that began on or after Sept. 23, 2012. For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the SBC must be provided beginning on the first day of the first plan year that began on or after Sept. 23, 2012.

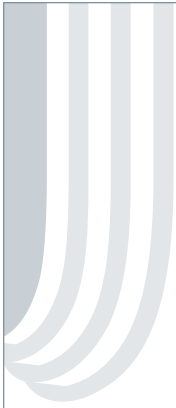
Terms and Definitions

What is a Summary of Benefits and Coverage (SBC) document?

The Summary of Benefits and Coverage document is intended to provide consumers with a concise document explaining, in plain language, simple and consistent information about health plan benefits and coverage. It will summarize the key features of the plan, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

What is the 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.

Requirements

What template should plans and issuers use? Is the Uniform Glossary required to be provided after the first year of applicability?

The SBC template for the second year of applicability (2014 and later) is available at <http://cciio.cms.gov> and <http://www.dol.gov/ebsa/healthreform>. These documents are authorized for use by group issuers and health plans, and individual health insurance carriers. No changes were made to the content of the Uniform Glossary or the requirement to provide it to members upon request.

Is the SBC required for both grandfathered and non-grandfathered plans?

Yes. The SBC is required for both grandfathered and non-grandfathered plans in the insured and self-funded market, as well as the individual market.

Must the header and footer be repeated on every page of the SBC?

No. If a plan or issuer chooses, it may include the header only on the first page of the SBC. In addition, a plan or issuer may include the footer only on the first and last page of the SBC, instead of on every page.

The deductible amount is \$250, but the Coverage Example is showing \$300, why is there a difference?

The calculator instructions provided by the Department of Health and Human Services (HHS) indicate that any dollar amount over \$100 is rounded to the nearest hundredth and any amount under \$100 to the nearest tenth.

What changes have been made to the SBC template for the second year of applicability (2014)?

The only change to the SBC template is the addition of statements of whether the plan or coverage provides minimum essential coverage (MEC) and whether the plan or coverage meets the minimum value (MV) requirements (60 percent of costs of benefits for a population). 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.

Penalties for Failure to Provide SBC or Uniform Glossary

Under what circumstances can penalties be imposed for failure to provide the SBC or the Uniform Glossary?

PHS Act section 2715(f) states that an entity is subject to a fine if the entity “willfully fails to provide the information required under this section.”

As stated in previous FAQs, the Departments’ basic approach to ACA implementation is: “[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law.” Accordingly, consistent with this guidance, during this first year of applicability, the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to comply.

Safe Harbors and Other Enforcement Relief

Safe harbors and other enforcement relief were provided by the Departments related to the requirement to provide an SBC and a Uniform Glossary for the first year of applicability. Will this relief be extended?

Yes. Current enforcement relief extended through 2014, including:

- ▶ 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

Is any relief available to provide information about MEC and MV without changing the SBC template?

Yes. If a plan or issuer is unable to modify the SBC template for disclosures required to be provided for the second year of applicability, the Departments will not take any enforcement action against a plan or issuer for using the template authorized for the first year of applicability, provided that the SBC is furnished with a cover letter or similar disclosure stating whether the plan or coverage does or does not provide MEC and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage does or does not meet the MV requirements under the ACA.



Consult your UnitedHealthcare representative if you have questions, or visit the United for Reform Resource Center at uhc.com/reform for more information.



The content provided is for informational purposes only and does not constitute medical advice. Decisions about medical care should be made by the doctor and patient. Always refer to the plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the ID card.

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