# Summary of Benefits and Coverage
## FACT SHEET
## Updated 8/28/2013

This fact sheet provides a high-level overview of the **Summary of Benefits and Coverage (SBC)** mandated by the Patient Protection and Affordable Care Act (PPACA).

### OVERVIEW

The Departments of Health and Human Services, Labor and Treasury issued regulations requiring health plans to provide a SBC and Uniform Glossary that clearly explain benefits and coverage within a standardized template with uniform language beginning 9/23/12. To develop these standards, the PPACA required the regulators named above to consult with the National Association of Insurance Commissioners (NAIC). The NAIC developed a template SBC, as well as a Uniform Glossary of commonly used health insurance terms, along with regulations detailing rules for when and how these documents must be provided to individuals and employer groups.

The SBC and Uniform Glossary must be distributed for insured commercial products offered to direct pay individuals, including Healthy New York, and insured employer groups. The insurer is not obligated to supply the SBC and Uniform Glossary to self-funded employer groups, but the health plan opted to create SBCs for self-funded employer groups. Medicaid, Family Health Plus, Child Health Plus, Medicare Advantage and Medicare Supplemental, stand-alone Dental, and stand-alone Vision products are excluded from the SBC and Uniform Glossary requirements.

### REGULATIONS

A SBC must be provided to insured employer groups and direct pay individuals 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, and upon request. PPACA requires that a SBC must be provided to applicants, enrollees, and policy or certificate holders. PPACA places responsibility to provide a SBC on the health plan and/or the employer group as follows:

- **For delivery to an insured employer group:** The health plan.
- **For delivery to members of insured employer groups:** The employer group and the health plan.
- **For delivery to members of self-insured employer groups:** The employer group or designated employer plan administrator of the plan as that term is defined under ERISA.

HHS has acknowledged that this will be a significant change for the marketplace and has agreed that good-faith efforts to comply with this mandate will be accepted. It will be important for employer groups and insurers to work together during this first year of SBC compliance to work out any challenges and issues that may arise. HHS guidelines can be found at http://www.dol.gov/ebsa/faqs/faq-aca9.html.

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**SBC PROVIDED BY HEALTH PLAN TO AN *EMPLOYER GROUP***

The regulations requires a health plan to provide a SBC to an insured employer group upon an application for coverage, or as soon as practicable following receipt of the application, but in no event later than 7 business days following receipt of the application. If there is any change to the information in the SBC before the first day of coverage, the health plan must update and provide a revised SBC to the employer group no later than the first day of coverage. The SBC must be provided upon request no later than 7 business days after receipt of the request.

The SBC must be provided upon renewal as follows:

- **Renewal when a re-application is required:** The SBC must be provided no later than the date on which the materials are distributed.
- **Automatic Renewal:** The SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.

**SBC PROVIDED BY HEALTH PLAN TO *INDIVIDUALS***

The regulations requires the employer groups and the health plan (for insured membership) to provide to each participant the SBC(s) for each benefit package the participant is eligible to select as part of application materials no later than the first date on which the individual is eligible to enroll. If there is any change to the information required 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. In order to reduce duplication, a single SBC may be provided to a family unless any individuals in the family are known to reside at a different address.

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**SBC CONTENT**

The regulation outlines the required content elements and format requirements for the SBC. These requirements include:

- A description of the coverage (including the cost-sharing), for each category of benefits identified in the template SBC;
- The exceptions, reductions, or limitations on coverage;
- The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
- Template language in the “Why it Matters” section;
- Uniform definitions;
- The renewability and continuation of coverage provisions;
- 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; and
- A uniform format, four double-sided pages in length, and 12-point font.

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**QUESTION & ANSWER**

**Q: When will Excellus BCBS begin sending SBCs to the employer groups?**

A: According to the regulations SBCs must be provided to employer groups and members *beginning* 9/23/12.

- SBCs must be provided to new employer groups and direct pay individuals looking to enroll on or after 9/23/2012
- SBCs must be provided to existing employer groups, group members, and direct pay enrollees upon their first renewal on or after 9/23/2012.
- SBCs must be provided within 7 days upon request beginning 9/23/2012.

**Q: When will SBCs be submitted to the employer group?**

**A:** Employer groups should expect to receive their SBCs when they receive their rate quote.

**Q: Will Excellus BCBS create SBCs for self-funded groups?**

**A:** Yes.

**Q: Will there be a charge for creating the SBCs for self-funded groups**

A: No.

**Q: Will Excellus BCBS mass mail SBCs to members of an employer group?**

A: No, the employer group will be responsible to distribute the SBCs to their members.

**Q: Will Chambers, Trusts and Associations (CTAs) be required to distribute SBCs to member firms and their employees?**

A: Yes. CTAs will be required to distribute SBCs to member firms and they will require member firms to distribute SBCs to their members.

**Q: What will it show on the SBC if there is no medical benefit?**

A: The SBC will show "Not covered."

**Q: What format is the SBC?**

A: The SBC will be a PDF in the required format. The automated solution only produces PDFs; therefore, no other format will be available.

**Q: What happens if an employer group does not have their drug and/or behavior health insurance with Excellus BCBS?**

**A:** From 9/23/12 until 1/1/14, employer groups will be allowed to distribute more than one partial SBC to their members. The employer group will be responsible to create or obtain the SBC from the other insurer for the benefits that are not administered through Excellus BCBS.

**Q: Will Excellus BCBS combine the SBCs for the employer groups that have drug and/or behavior health benefits with another insurer?**

A: Yes. Excellus BCBS is willing to assist the employer groups in combining the drug and/or behavior health benefits that they have with another insurer. Employer groups must give their Account Manager the drug and/or behavior health benefit details in writing.

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**Q:** **When must an employer group provide an SBC to their members?**

A: The employer group must provide the SBC(s) and any application materials to each participant no later than the first day the participant is eligible to enroll in coverage. The employer group must provide the SBC(s) and any renewal application materials must be provided to a renewing participant no later than 30 days prior to the first day of the new coverage period. The employer group must provide the SBS(s) within 7 days upon request from member.

**Q:** **Are there any penalties for failing to provide a SBC and Uniform Glossary?**

A: Employer groups and health plans are subject to a fine if they do not comply with the SBC regulation. The fines will be waived the first and second year, if good faith effort can be demonstrated.

**Q:** **When must a health plan provide notice of a benefit change that is not reflected in the SBC?**

A: If a health plan makes a material modification to coverage that would affect the content of the current SBC, the plan must provide notice of the change to enrollees no later than 60 days prior to the effective date of the change. The foregoing notice requirement does not apply to changes that occur in connection with the renewal of coverage.

**Q:** **How do employer groups or members obtain copies of the Uniform Glossary?**

A: The Uniform Glossary can be found at www.excellusbcbs.com or www.cciio.cms.gov

**Q:** **What products are excluded from the SBC requirement?**

A: Medicaid, Family Health Plus, Child Health Plus, Medicare Advantage, Medicare Supplemental, stand-alone dental and stand-alone vision products are excluded from the SBC requirement.

**Q:** **When will the SBC template be updated to show the 2014 mandated language.**

A: The SBC template will be updated in September, 2013, and will start appearing on any new SBCs created on or around October 1, 2013.

**Q:** **What changes are in the 2014 mandated language?**

A: The 2014 changes require the SBC to indicate if the benefit plan meets the “minimum essential coverage" (MEC) and the “minimum value” (MV).

## Coverage Examples

**Q:** **Why are there copays in the Maternity example when there are no copays listed in the "front" of the SBCs?**

A: The copays in the coverage examples include Medical and Rx copays, whereas the copays listed under the Common Medical Event section only refer to Medical copays.

**Q:** **Why are there copays in the Diabetic example if my generic copay is $0?**

A: The default Diabetic supplies copay is the NYS mandate, which is equal to the PCP copay. This means that even if there is no Rx copay, the Diabetic example may include PCP copays for those supplies.

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**Q: There is no Rx coverage included in my plan, so the total "Prescriptions" amount in the "Sample care costs" comes from the "Limits or Exclusions" section of "Patient pays". Why aren't these 2 amounts equal?**

A: With the exception of Vaccines, the values in "Sample care costs" are rounded to the nearest $100. To provide more detailed values for the "Patient pays" section, the amounts are rounded to the nearest $10. For example, a $150 Rx Limits and exclusions amount will show up as $200 in the Sample care costs Prescriptions row.

## Deductible

**Q: Showing only the coinsurance in the "Your Cost" column is confusing. Why doesn't it show both deductible and coinsurance?**

A: The SBC template and instructions are created by Health and Human Services (HHS). Information about the deductible is on page 1 : "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." And on page 2: "Coinsurance 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 coinsurance payment of 20% would be $200. This may change if you haven't met your deductible."

**Q: Should the answer to "Are there other deductibles for specific services?" be yes because home health care has a $50 deductible?**

A: No, because the deductible is included in the overall deductible, it is not a separate deductible. The member will only pay $50 towards the overall deductible, before applying the coinsurance to the home health care benefits.

## Prenatal and Postnatal Care

**Q: Why is prenatal care covered in full?**

A: Preventive Services for Women mandate dictates that Prenatal Services are Covered in Full, if the group is not grandfathered.

**Q: Does the physician bill separately for postnatal?**

A: The bill from the physician for the delivery is a one line global code (in majority of the cases); postnatal care would not incur a separate cost. The delivery is listed as a separate benefit in the SBC. The postnatal cost share is the delivery cost share; they are not two different benefits.

## Rehabilitation and Habilitation Services

**Q: What are habilitation services?**

A: Habilitation services are the inpatient rehabilitation services.

**Q: What are rehabilitation services?**

A: Inpatient and outpatient covered therapies (speech, physical, occupational).

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## Eye Care

**Q: Why doesn't the SBC show eye care benefits for both adult and child?**

A: The SBC template specifically asks about eye care benefits for a child not the adult. Adult eye care is listed in either the "Other Covered Services" or "Services your plan does not cover" box.

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## GLOSSARY

**Health Plan**
– An insurance organization that offers health insurance products and services to the public.

**Employer Group**
– A legally formed, sole proprietorship, partnership or corporation that is qualified to offer health insurance coverage to employees.

**Subscriber**
– The member of a group to whom the health insurance certificate is issued.

**Dependent**
– Any member approved to receive coverage under a subscribers health insurance contract.

**Individual**
– Any person either interested in buying or has purchased health insurance products or services directly from a health plan.

**Uniform Glossary**
– The uniform glossary is a common set of definitions and medical terms designed to help consumers understand and compare benefits.

**Material Modification**
– Any benefit change that changes the benefit coverage and contract between the health plan and subscriber.

**ERISA**
– The Employee Retirement Income Security Act of 1974, or ERISA, protects the assets of millions of Americans so that funds placed in retirement plans during their working lives will be there when they retire.