



## EMPLOYER GUIDE

SUMMARY OF BENEFITS AND COVERAGE

GLOSSARY OF HEALTH COVERAGE AND MEDICAL TERMS



# Summary of Benefits and Coverage

On Feb. 14, 2012, the Departments of Treasury, Internal Revenue Service, Labor, Health and Human Services, and Employee Benefits Security Administration released a final rule that implemented disclosure requirements under section 2715 of the Public Health Service Act.

This health insurance market reform under the Patient Protection and Affordable Care Act requires group health plans and health insurance issuers in the group market to provide a summary of benefits and coverage and uniform glossary to members of their health plans.

Final Regulations were again issued in June 2015. A revised SBC template and uniform glossary was finalized for Plan Year 2021.

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## What's an SBC and a Uniform Glossary?

The Summary of Benefits and Coverage or "SBC" and Glossary of Health Coverage and Medical Terms or "Uniform Glossary" are designed to help consumers better understand their health coverage and allow for easy comparison of other coverage options when shopping, applying, enrolling and re-enrolling into a health plan. The SBC is a resource for your employees that will summarize your health plan options including:

- Deductible
- Out-of-pocket and annual limits
- In- and out-of-network provider coverage
- Coverage of common medical events
- Excluded services
- Common covered services
- Rights to continue coverage
- Member grievance and appeal rights
- Coverage examples for having a baby and managing type 2 diabetes


The "Uniform Glossary" lists commonly used terms in insurance coverage. You can access the glossary by logging on to [www.aultcare.com](http://www.aultcare.com).

### Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

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.\[insert\]](http://www.[insert]) or by calling 1 800 [insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	<b>\$500</b> person / <b>\$1,000</b> family Doesn't apply to preventive care	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
Are there other deductibles for specific services?	Yes. <b>\$300</b> for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers <b>\$2,500</b> person / <b>\$5,000</b> family For non participating providers <b>\$4,000</b> person / <b>\$8,000</b> family	The <b>out of pocket limit</b> 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 <b>out of pocket limit</b> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See <a href="http://www.[insert].com">www.[insert].com</a> or call 1 800 [insert] for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> 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 <b>excluded services</b> .

Questions: Call 1 800 [insert] or visit us at [www.\[insert\]](http://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.\[insert\]](http://www.[insert]) or call 1 800 [insert] to request a copy.

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

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Corrected on May 11, 2012

## What is Culturally and Linguistically Appropriate Manner?

This requirement provides employees and dependents the option to request their SBC in a non-English language if they reside in a county that meets or exceeds a 10 percent threshold of non-English speaking residents. The SBC that we provide will contain directions for non-English speaking individuals to receive further information in their non-English language.

## How do I meet the Electronic Disclosure requirements to distribute the SBC to my employees?

Under the Department of Labor Electronic Disclosure requirement, if your employees are able to effectively access documents provided in electronic format at their worksite (i.e. e-mail) and this access is a part of their duties as an employee, you can send the SBC to them electronically. You can also allow the employees to elect to receive their SBC electronically.

Eligible employees (not currently enrolled) can receive the SBC electronically as long as a paper version option is available upon request. You can accomplish this by email, e-card, posting on your intranet or sending a postcard.

## What happens if I fail to comply?

### POTENTIAL FINES AND PENALTIES

- Up to \$1,000 per day (adjusted for inflation) for each instance of willing non-compliance
- A fine of \$100 per day per affected individual until compliant

## Who will provide me with the materials I need for distribution to my employees?

As your health issuer or third-party administrator, we are committed to providing you with the tools that you need to meet this regulatory requirement.

- We will provide you with an SBC master copy for distribution (electronically or paper copy) for your employees, dependents and eligible employees for health insurance coverage. This will include an SBC for each benefit package you offer and a new SBC when coverage changes.
- Continuously monitor changes to regulation that may impact you.

## When will I receive my SBC?

We will deliver your SBC to you at the following times:

- Upon my application for coverage or within 7 days
- Within 7 days upon my request
- If terms of my plan are not yet final, upon the first day of coverage
- Upon changes to my plan
- If automatically re-enrolled, a new SBC will be provided at that re-enrollment

## Who should receive the SBC?

If you have an employee and all of the dependents reside at one address, only one SBC is required to be distributed.

However, if an employee has dependents who have an alternate address, you are required to distribute an SBC to those alternate addresses.

You are also required to distribute an SBC to **all of your employees who are eligible for health insurance coverage, even if they are not currently enrolled in your health plan.**

## When do I need to distribute the materials?

### OPEN ENROLLMENT

You need to provide the SBC with open enrollment materials. If you do not hold an open enrollment period, provide the SBC no later than the first date your employees are eligible to enroll for coverage.

### ONLINE ENROLLMENT

If you offer online enrollment, you are permitted to provide the SBC at the time of online enrollment or online renewal of coverage electronically but must provide the option to receive a paper copy.

### AUTOMATIC RENEWAL

If you have an automatic renewal, the SBC must be provided 30 days prior to the first day of the new plan year. This SBC will reflect the plan that the employee and dependents are currently enrolled.

### UPON REQUEST

If you have an employee or dependent who requests an SBC or Uniform Glossary, you must fulfill the request within seven business days. If the request is online, then you can deliver it electronically but you must provide the option to receive a paper copy.

### SBC CHANGES

If the SBC changes from what was distributed at enrollment, you must provide an updated SBC prior to the first day of coverage.

### SPECIAL ENROLLMENT

For Special Enrollment, you must provide an SBC within 90 days after they enrolled in your plan.

### MIDYEAR BENEFIT CHANGES

If you make a midyear change to your plan that changes the content of your SBC, you must provide a 60-day advance notice to employees. This can be complete via a new SBC or a separate notice (summary of material modification).

## Frequently Asked Questions

### 1. *Does this regulation impact small and large groups?*

Yes. Whether you are a small or large employer group, the SBC requirements apply to your health plan.

### 2. *Does this apply to both fully insured and self-insured plans?*

Yes, this impacts both fully insured and self-insured plans.

### 3. *Am I exempt because I am in a “grandfathered” plan?*

No, the SBC requirement applies to both “grandfathered” and “non-grandfathered” plans.

### 4. *Do I need an SBC for stand-alone dental or vision benefits?*

No, the SBC regulations do not apply to stand-alone excepted benefits. Excepted benefits are generally benefits that require the individual to pay an additional premium.

### 5. *Can I combine the SBC and Uniform Glossary with other documents?*

Yes, as long as the SBC is displayed at the beginning.

### 6. *Do COBRA enrollees receive SBCs?*

Yes, COBRA enrollees have the same rights as other enrollees to receive SBCs.

### 7. *Do I have to provide the SBC and Uniform Glossary in color?*

No, you are permitted to provide in color or grayscale.

## Glossary of Health Coverage & Medical Terms

This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

**Bold blue text** indicates a term defined in this Glossary. Also, See page 60 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

### Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

### Appeal

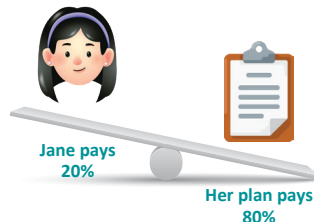
A request for your health insurer or plan to review a decision or a **grievance** again.

### Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you for covered services.

### Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any **deductibles** (See page 4 for a detailed example.) you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



### Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

### Deductible

The amount you owe for health care services your **health insurance** or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



### Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

### Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

### Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

### Emergency Room Care

Emergency services you get in an emergency room.

### Emergency Services

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

### Excluded Services

Health care services that your **health insurance** or plan doesn't pay for or cover.

### Grievance

A complaint that you communicate to your health insurer or plan.

### Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

### Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

### Home Health Care

Health care services a person receives at home.

### Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

### Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

### Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

### In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your health insurance or plan. In-network **co-insurance** usually costs you less than out-of-network co-insurance.

### In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to **providers** who contract with your **health insurance** or plan. In-network co-payments usually are less than **out-of-network co-payments**.

### Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

### Network

The facilities, **providers** and suppliers your health insurer or plan has contracted with to provide health care services.

### Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

### Out-of-network Co-insurance

The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

### Out-of-Network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do not contract with your **health insurance** or plan. Out-of-network co-payments usually are more than **in-network co-payments**.

### Out-of-Pocket Limit

The most you pay during a policy period ( usually a year) before your **health insurance** or plan begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or (See page 4 for a detailed example.) health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.

### Physician Services

Health care services a licensed medical physician (M.D. - Medical Doctor or O.O. - Doctor of Osteopathic Medicine) provides or coordinates.

### Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

### Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

### Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance

or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

### Premium

The amount that must be paid for your health insurance or plan. You and/ or your employer usually pay it monthly, quarterly or yearly.

### Prescription Drug Coverage

Health insurance or plan that helps pay for prescription drugs and medications.

### Prescription Drugs

Drugs and medications that by law require a prescription.

### Primary Care Physician

A physician (M.D. - Medical Doctor or O.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

### Primary Care Provider

A physician (M.D. - Medical Doctor or O.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

### Provider

A physician (M.D. - Medical Doctor or O.O. - Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

### Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

## Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

## Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose,

manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

## UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

## Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

## How You and Your Insurer Share Costs – Example:

Jane's Plan Deductible: \$1,500 | Co-Insurance: 20% | Out-of-Pocket Limit: \$5,000

January 1<sup>st</sup>

Beginning of Coverage Period



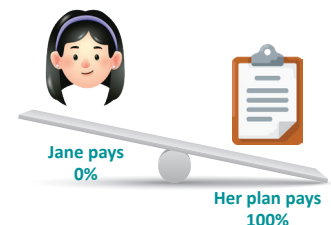
Jane hasn't reached her \$1500 deductible yet.

Her plan doesn't pay any of the costs.

Office visit costs: \$125  
Jane pays: \$125  
Her plan pays: \$0

December 31<sup>st</sup>

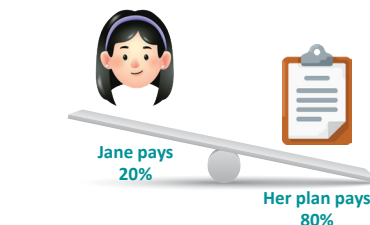
End of Coverage Period



Jane reaches her \$5,000 out-of-pocket limit.

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$200  
Jane pays: \$0  
Her plan pays: \$200



Jane reaches her \$1500 deductible, co-insurance begins.

Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: \$75  
Jane pays: 20% of \$75 = \$15  
Her plan pays: 80% of \$75 = \$60