Employer’s Guide to the
Summary of Benefits and Coverage
How to Prepare, Review and Distribute a
Summary of Benefits and Coverage (SBC)

Janae Schaeffer, JD
Edward Fensholt, JD
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PART I: AN OVERVIEW OF THE SBC REQUIREMENT

A. Background

The federal health reform law, the Patient Protection and Affordable Care Act, expands ERISA’s disclosure requirements by requiring that a summary of benefits and coverage (SBC) be provided free of charge to employees eligible for coverage prior to enrollment or re-enrollment. The SBC rules also apply to plans not subject to ERISA, such as state and local governmental plans, and plans maintained by churches. The summary must accurately describe the “benefits and coverage under the applicable plan or coverage.” ERISA plans must comply with the SBC requirement in addition to ERISA’s Summary Plan Description and Summary of Material Modifications/Summary of Material Reductions disclosure requirements. Significant penalties—$1,000 per violation—may be imposed for failing to comply with the SBC rules.

The SBC must:

- Not exceed four double-sided pages,
- Be provided to participants free of charge, and
- Precisely honor specific language and formatting requirements—all symbols, bolding, colors and shading, as well as wording, must be duplicated exactly, with limited exceptions. SBC templates and instructions issued by federal regulatory agencies are very detailed, and in most cases, the suggested language must be used.

To the extent a plan’s terms are difficult to summarize in an SBC in accordance with the SBC template instructions, the template should be completed in a manner that is as consistent with the instructions as possible. This may occur, for example, if a plan provides:

- a different structure for provider network tiers or drug tiers than is represented in the SBC template,
- different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), or
- different cost-sharing based on participation in a wellness program.
B. Which Plans Must Be Summarized in an SBC?

The requirement to distribute SBCs applies to all group health plans subject to health reform. The requirement therefore applies to insured and self-insured health plans subject to reform. A plan’s “grandfathered” status under health reform is irrelevant.

But some health plans dodge the requirement because they’re not subject to reform. Here’s a list of common health plans, and a description of the extent to which the SBC rules apply to them:

**Dental and Vision Plans:** Limited scope dental and vision plans are not required to comply. If medical and dental and/or vision coverage are bundled such that (1) the dental and/or vision coverage is provided under the same contract as medical, or the dental/vision coverage is self-insured, and (2) employees pay a single premium, with no opportunity to opt out of the dental/vision coverage and pay a lower premium for the medical coverage, then the SBC requirements apply to the dental/vision coverage too. Where the medical coverage is thus bundled with dental and/or vision and supplied under the same medical plan, the medical plan’s SBC should attempt to include a discussion of the dental/vision benefit.

**Health Flexible Spending Accounts (Health FSAs):** Health flexible spending accounts are not required to comply as long as they’re considered an “excepted benefit” under health reform. Although health FSAs typically are not subject to the SBC requirements, a plan sponsor may choose to reference its health FSA—and the fact that the dollars available from the FSA may be used to satisfy deductibles and other out-of-pocket expenses under the medical plan—in the comprehensive medical plan’s SBC.

**Health Savings Accounts (HSAs):** Health Savings Accounts are not considered health plans, so there is no requirement to supply an SBC with respect to an HSA. Note, however, that some people confuse the literal HSA with the companion high deductible health plan (HDHP), sometimes referring to the latter as an “HSA plan.” The HDHP is subject to the SBC rules. Although HSAs are not subject to the SBC requirements, a plan sponsor may reference an HSA program—and the fact that the dollars available from an HSA may be used to satisfy deductibles and other out-of-pocket expenses under the HDHP medical plan—in the comprehensive medical plan’s SBC.

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1 This will be the case unless the health FSA supplies significant employer contributions (at least $500 per year) or is available to employees who are not also offered comprehensive medical coverage.
**Employee Assistance Programs (EAPs):** These appear to be subject to the SBC requirements, where they supply counseling as opposed to merely referrals. Where the EAP is bundled with (considered part of, and reflected in the Form 5500 for) the health plan, the health plan’s SBC may refer to the EAP, or may be modified to refer to the EAP. Where it’s not—where it’s a stand-alone ERISA plan, for example—federal authorities will likely expect the sponsor or carrier to supply an SBC. That may be a hassle, at least for 2012, as EAP vendors appear to be slow coming to the SBC preparation party. Frankly, there’s not a good or easy answer to the question, “How do we supply an SBC with respect to an EAP?” because the SBC templates were not prepared with EAPs in mind.

**Health Reimbursement Arrangements (HRAs):** Health reimbursement arrangements (HRAs) will usually be subject to the SBC requirements. Often, HRAs are integrated with major medical coverage, such as when a health insurer administers the HRA alongside the comprehensive medical plan, and automatically pays an enrollee’s out-of-pocket expenses from the HRA. Federal authorities intend that such an integrated HRA benefit be described somehow in the major medical plan’s SBC. For the first year of the SBC requirements, federal authorities essentially say, “Do your best” to describe the HRA benefits and their effect on the major medical coverage (e.g., they may be used to offset out-of-pocket expenses).

Where the HRA is *not* integrated with the major medical coverage—where it is a stand-alone reimbursement program that may be used to offset major medical plan deductibles etc. but also to reimburse out-of-pocket expenses not covered by the major medical plan—in theory it should have its own SBC. There’s not a good or easy answer to this dilemma either, as the SBC templates were not prepared with HRAs in mind. See also the discussion on the following page regarding retiree-only plans as exempt from the SBC rules. Thus, a retiree-only HRA, operating as a separate plan, would not be subject to the SBC requirements.

**Wellness Programs:** Where a wellness program is offered as part of the major medical plan, and could affect a participant’s cost-sharing under the plan (for example, because the wellness program supplies premium discounts or surcharges, deductible discounts or surcharges, etc.), the coverage examples in the SBC for the major medical plan should note the effect of the wellness program when discussing the assumptions used in creating the examples.

**Expatriate Plans:** These pose unique issues. Federal authorities recognize that expatriate coverage carries additional administrative costs and barriers in compiling SBCs. Therefore, expatriate plans get a free pass for the first year the SBC rules are in effect; authorities will not take any enforcement action.
against a group health plan or group health insurance issuer for failing to provide an SBC with respect to expatriate coverage for that first year.

After that, instead of summarizing coverage for items and services provided outside the U.S., a plan may provide an internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. If the plan provides coverage within the U.S., the plan is still required to provide an SBC that accurately summarizes benefits and coverage available within the U.S.

**Long-Term Care Plans:** Although contemporary long-term care plans typically supply some form of medical benefit, they are “excepted benefits” under health reform—and thus not subject to the SBC requirements—when they are offered under a separate insurance contract, which is usually the case.

**Retiree-Only Plans:** Retiree-only plans—whether benefitting pre-65 or post-65 retirees, or both—dodge the SBC requirement because they are treated as “excepted benefits”—and thus are not subject to the SBC requirements—due to the fact that they don’t cover at least two active employees.

**Insured Plans No Longer Actively Marketed:** Sometimes an insurer providing fully-insured group coverage to an employer stops offering to the marketplace the same insurance contract held by the employer. Federal authorities have given these insurers a one-year reprieve from the SBC rules, with respect to these fully-insured plans that are no longer being actively marketed.²

C. **Who Must Provide the SBC . . . the Insurer or the Plan Sponsor?**

For self-insured plans, the “plan administrator” must supply the SBC. That’s usually the employer/plan sponsor. If you’re not sure who the plan administrator is (this is a term of art, by the way; it doesn’t mean

² Federal authorities had this to say about these contracts no longer actively marketed:

*The Departments understand that most plans and issuers have to develop new databases and technology systems in order to extract information about coverage terms and provide SBCs. The Departments also understand that, with respect to insurance products that are no longer being offered for purchase (sometimes referred to as closed blocks of business), there is a significant volume of data that is not stored in electronic form or is not stored in an information system that is compatible with the new electronic systems being developed for the SBC.*

*Accordingly, due to the additional administrative complexities with respect to providing SBCs with respect to closed blocks of business, the Departments will not take any enforcement action against a plan or issuer for failing to provide an SBC before September 23, 2013 with respect to an insured product that is no longer being actively marketed for business, provided the SBC is provided no later than September 23, 2013 (at which time, enrollees and small employers will have new opportunities to compare coverage options available through an Exchange).*
the third-party claims administrator or claims payor, usually), check the plan’s summary plan description (SPD). The SPD usually lists the plan administrator, in the SPD’s “General Provisions” or under a similar title or heading.

For insured plans, the rules require the insurer or the plan administrator to supply the SBC. This means that if the insurer fails to supply the SBC, the plan administrator/plan sponsor will have to do so, or risk penalties. If the insurer provides an SBC that is both timely and compliant, the plan administrator’s obligation is satisfied.

What happens if an insurer or other third party agrees to timely supply a compliant SBC to the plan’s enrollees and others, but fails to do so? Federal authorities say they normally won’t take action against the plan administrator/plan sponsor in such a case, if:

- The plan administrator/plan sponsor enters into a binding contractual agreement under which the third party assumes responsibility to: (1) complete the SBC; (2) provide required information to complete a portion of the SBC; or (3) deliver the SBC; and
- The plan administrator/plan sponsor monitors the third party’s performance under the contract; and
- The plan administrator/plan sponsor promptly corrects a violation of the SBC rules once it has knowledge of the violation and the information to correct it (if the plan administrator/plan sponsor has knowledge of a violation and does not have the information to correct it, it must communicate with participants and beneficiaries regarding the violation and begin taking “significant steps” as soon as practicable to avoid future violations).

**Recommendation:** These requirements may be a bit challenging to satisfy. If the insurer informs an employer that it (the insurer) intends to distribute an SBC to plan participants and to make the SBC available to individuals eligible for coverage but not enrolled, it would be best if the employer had this commitment in writing—if only in an e-mail—and ensure the commitment reflects the date by which the insurer will do so (and of course that date should be consistent with the SBC requirements).

Ideally, the agreement should include the employer’s right to indemnification if the insurer fails to timely distribute the SBCs to all people entitled to receive them, or fails to prepare an SBC that complies with all the instructions. However, it may be difficult to obtain such indemnification as a practical matter.
In subsection D, below, we may refer to “the plan” as supplying the SBC. When we make such a reference to the plan, we mean the insurer or plan administrator/plan sponsor, as the case may be.

**D. Delivery: How and When Must an SBC be Supplied, and to Whom?**

The rules concerning how and when the SBC must be provided differ depending on whether:

- The individual is **enrolled** in coverage, or merely **eligible** for coverage but not enrolled;
- The individual’s enrollment occurs **during** open enrollment, or **later** (such as during a special enrollment opportunity);
- The enrollment occurs **online**, or in **other ways** (e.g., on paper); and
- With respect to individuals who are already enrolled in coverage, their re-enrollment occurs **automatically** without opportunity to change coverage options, or (instead) they must either affirmatively re-enroll each year or their re-enrollment is automatic but they have an option during open enrollment to change coverage options.

One of the most potentially confusing aspects of the SBC delivery rules concerns just how an SBC is “provided.” The rules require a plan to “provide” an SBC at a variety of times. Sometimes to “provide” an SBC means to literally give it to the individual, but at other times it simply means to **make it available**, which may occur electronically such as via an email or via an Internet posting.

The delivery rules are summarized in the grid attached as Appendix A. A more detailed, narrative description appears below.

**Current Enrollees Affirmatively Re-Enrolling OR Whose Re-Enrollment is Evergreen but the Enrollees May Affirmatively Change Coverage Elections During Open Enrollment**

For current enrollees who:

1. Must affirmatively re-enroll (that is, current enrollees who must sign up for coverage each year or their old coverage election lapses and they’re treated as not having elected coverage for the new year), or
2. May choose to do nothing and be automatically re-enrolled in their existing coverage option for the year, but who may also choose to affirmatively change coverage elections during open enrollment…

the SBC requirements apply to open enrollment periods beginning on or after September 23, 2012. The plan should have the SBCs prepared and ready by the first day of the open enrollment period. The plan has an affirmative obligation to deliver to the current enrollee the SBC for the option the enrollee is currently enrolled in (we presume the obligation is to supply an SBC reflecting changes to that option for the upcoming year). If the updated version of the SBC (for the coming new plan year) is not yet prepared, the plan should supply the current year’s version of the SBC, and then provide the updated version prior to the first day of the coming new plan year.

The SBC should be included with open enrollment materials. If open enrollment occurs online (electronically), the SBC may be provided as part of the online enrollment process (presumably an electronic version of the SBC that the enrollee may view and print, or a downloadable version that the enrollee may download and print). There’s little detailed guidance on how the SBC may be provided electronically, where open enrollment occurs electronically. May the SBC be sent via an email, where employees actually accomplish enrollment through some other electronic portal? Is it adequate to simply post a link to the SBC on the electronic portal the employee must enter to enroll or re-enroll? Presumably, both of these methods would be acceptable.\(^3\)

According to an FAQ issued by federal authorities, furnishing the SBC to the participant (i.e., the covered employee) is deemed to accomplish delivery to covered dependents, even if the SBC is provided electronically, unless the plan is aware that an enrolled dependent does not live with the employee.

**Recommendation:** Plan sponsors may wish to add language to enrollment forms whereby enrolling employees acknowledge that where the plan supplies an SBC to a participant, the provision of the SBC to the participant will be deemed to accomplish delivery of the SBC to his or her dependents unless the participant notifies the plan that a dependent resides elsewhere.

If the re-enrollment does not occur online, the insurer or plan administrator may include a paper version of the SBC with the paper enrollment packet, or may deliver the SBC electronically. But in this latter case the rules governing electronic distribution are more challenging. The plan must comply with ERISA’s

\(^3\) Federal authorities merely say that the SBC may be provided electronically “in connection with” an online open enrollment process.
rules governing electronic delivery of required notices. Those rules essentially require that the recipient either have access to the employer’s electronic network as an integral part of his or her duties, or the plan must obtain the recipient’s consent to receive the SBC electronically. The consent may be obtained by sending the individual an email, and allowing the individual to “consent” to the electronic distribution by clicking on a link to the SBC. Presumably, the employer’s network would be able to record the email addresses from which online SBCs were accessed. See Appendix B for a discussion of the Labor Department rules that apply in this case.

This “consent” requirement may prove particularly challenging when the plan must supply an SBC to a non-employee, such as a COBRA beneficiary, for whom the plan may not have a valid email address.

**Recommendation:** As a practical matter, where the plan conducts enrollment on paper and the employee has dependents on the plan, the open enrollment materials (including the SBC) should probably be mailed to the employee’s home, addressed to the employee and family, because delivering the SBC to the employee in this fashion is also deemed to accomplish delivery to the dependents unless the plan is aware that a dependent lives elsewhere. If the re-enrollment occurs on paper and the employee has merely “employee-only” coverage, the enrollment materials (including the SBC) may be hand-delivered, mailed or sent electronically, but if sent electronically, it appears the delivery must comply with the Labor Department’s detailed rules for electronic delivery, as described above.

There’s more information, concerning flexibility under the rigid SBC formatting rules, for electronically-displayed SBCs (displayed on a webpage, for example) in the discussion under subsection F, below.

**Current Enrollees Whose Re-Enrollment Occurs Automatically Without Opportunity to Change Coverage Options**

For current enrollees whose re-enrollment occurs automatically (and where there is no opportunity to change coverage options during open enrollment), the same effective date applies, that is, the rules apply for open enrollments occurring on or after September 23, 2012, but the deadline for actually providing the SBC is later. It’s not entirely clear whether this rule applies to:

- Currently enrolled participants whose enrollment is “evergreen,” and
- There is only one coverage option, and
- The participant may choose to affirmatively disenroll,
but we presume that’s the case.

The SBC must be provided not fewer than 30 days prior to the plan’s new year. There’s an exception (in the case of insured plans) where the renewal is not finalized or the carrier has not committed to the renewal by that 30-day deadline. In that case, the SBC should be provided as soon as reasonably possible, but not later than seven business days after the insurer issues the renewed policy or supplies written confirmation of intent to renew, whichever is earlier. The plan satisfies the “seven business day” rule if it sends the SBC within seven business days.

The plan has an affirmative obligation to deliver to the current enrollee the SBC for the option the enrollee is currently enrolled in (we presume the obligation is to supply an SBC reflecting changes to that option for the upcoming year). If the updated version of the SBC (for the coming new plan year) is not yet prepared, the plan should supply the current year’s version of the SBC, and then provide the updated version prior to the first day of the coming new plan year.

The rules here are not terribly clear, but presumably if the plan’s open enrollment process is occurring electronically, the SBC may be provided as part of the online enrollment process (presumably an electronic version of the SBC that the enrollee may view and print, or a downloadable version that the enrollee may download and print). Again, there’s little detailed guidance on how the SBC may be provided electronically, where open enrollment occurs electronically. May the SBC be sent via an email, where employees actually accomplish enrollment through some other electronic portal? We assume so.\(^4\)

But the safe play—and the required method where enrollment does not occur online—is to deliver a paper copy of the SBC, or (apparently) deliver the SBC electronically in accordance with ERISA’s rules governing electronic delivery of required notices. Those rules essentially require that the recipient either have access to the employer’s electronic network as an integral part of his or her duties, or the plan must obtain the recipient’s consent to receive the SBC electronically. This “consent” requirement will prove challenging when the plan must supply an SBC to a non-employee. See Appendix B for a discussion of the Labor Department rules that apply in this case.

As a practical matter, where the employee has dependents on the plan the best course may be to mail the SBC to the employee’s home, addressed to the employee and family, because delivering the SBC to the

\(^4\) Federal authorities merely say that the SBC may be provided electronically “in connection with” an online open enrollment process.
employee in this fashion is also deemed to accomplish delivery to the dependents unless the plan is aware that a dependent lives elsewhere. If the employee has merely “employee-only” coverage, the SBC may be hand-delivered, mailed or sent electronically. But again, if sent electronically, out of an abundance of caution we think the delivery should comply with the Labor Department’s detailed rules for electronic delivery, described in Appendix B.

**Individuals Eligible but Not Enrolled, Who Enroll During Open Enrollment**

For individuals who are not enrolled but are eligible to enroll during open enrollment, the SBC rules apply to the open enrollment process if it begins on or after September 23, 2012. But the manner in which the SBCs are “provided” is different, if the insurer/plan sponsor wants it to be.

It appears the plan does not have an **affirmative** obligation to deliver the SBCs to these individuals who are merely eligible, and not already enrolled. Rather, it appears the plan is required only to make available to these individuals the SBCs for the coverage options in which they are eligible to enroll. The plan should make the SBCs “available” no later than the first day the person may enroll.

The SBCs may be made available electronically, such as via email or an Internet posting. If via an Internet posting, federal rules require the plan to satisfy certain requirements:

- The SBC must be in a readily accessible format (such as in an html, MS Word, or pdf format);
- The SBC must be provided in paper form free of charge upon request; and
- The plan must timely advise its participants and beneficiaries that the SBC is available on the web and provide the web address. Plans may make this disclosure (sometimes referred to as the “e-card” or “postcard” requirement) by email, but unless the participant accesses the employer’s electronic data system at the workplace or unless the employer has a valid email address for the participant, the more prudent play may be to send the card by regular mail.

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5 May the SBC be provided electronically via an **Intranet** site, rather than Internet site? In the actual SBC regulations, federal authorities (when discussing the shortcuts for supplying SBCs to individuals who are eligible for coverage but not enrolled) refer to providing the SBC “electronically (such as by email or an Internet posting)...” The use of “such as” suggests that other methods may be appropriate too, as long as they are “readily accessible” to the individuals.

If the plan is able to post its SBCs on an Internet site and refer to that site in the SBC, this would surely satisfy the requirement (the SBC rules were written with insurance companies mostly in mind, hence the desire to have the
Federal authorities have offered the following model language for the “postcard” supplied to eligible individuals, alerting them to the availability of SBCs on an Internet site:

**Availability of Summary Health Information**

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: www.website.com/SBC. A paper copy is also available, free of charge, by calling 1-XXX-XXX-XXXX (a toll-free number).

Interestingly, there is not a requirement that, once the eligible individual actually enrolls, the plan reach back out to him or her and supply him or her with the SBC for the coverage option in which he or she actually enrolled. That affirmative obligation won’t arise until the next open enrollment period, when the newly enrolled person will then have the status of someone already enrolled.

**Individuals Eligible but Not Enrolled, Who Enroll Outside of Open Enrollment (e.g., Initial Enrollment, Special Enrollment)**

Some eligible but not currently enrolled individuals may enroll outside of the plan’s open enrollment period. These include individuals who enroll upon becoming eligible mid-year (say, upon hire or transfer to an eligible class of employees) and those who enroll during a HIPAA special enrollment window, such as where the individual marries or experiences the birth or adoption of a child, or loss of coverage elsewhere.
These eligible individuals must, while they’re eligible, have access to the SBC for each coverage option in which they may enroll. The plan should make the SBCs available no later than the first day the person may enroll (i.e., the first day they become eligible).

The SBCs may be made available electronically such as via email or Internet posting if the plan satisfies certain requirements:

- The document must be in a readily accessible format (such as in an html, MS Word, or pdf format);
- The SBC must be provided in paper form free of charge upon request; and
- The plan must timely advise its participants and beneficiaries that the SBC is available on the web and provide the web address. Plans may make this disclosure (sometimes referred to as the “e-card” or “postcard” requirement) by e-mail, but unless the participant accesses the employer’s electronic data system at the workplace or unless the employer has a valid email address for the participant, the more prudent play may be to send the card by regular mail.

Federal authorities have offered model language for the “postcard” supplied to eligible individuals. See the model language above, in the section dealing with eligible individuals who enroll during an open enrollment period. See also footnote 5, which addresses the question whether posting SBCs on an Intranet site may be considered adequate.

What happens when the person actually enrolls? If the enrollment occurs other than during a HIPAA special enrollment period, the plan’s obligation is no different than when an eligible individual first enrolls during open enrollment: There is no duty to affirmatively reach out to the individual and deliver the SBC for the option in which he or she has just enrolled.

But oddly, that’s not the rule where the enrollment occurs during a HIPAA special enrollment period. In that case, the plan must affirmatively supply to the enrollee the SBC for the coverage option in which he or she enrolled, and must do so within 90 days after the special enrollment. Remember that HIPAA special enrollments may arise where an employee marries, or experiences the birth or adoption (or placement for adoption) of a child; where an employee or dependent loses Medicaid or CHIP coverage or premium payment assistance under Medicaid or CHIP; or where an employee or dependent loses coverage elsewhere for certain reasons, such as loss of eligibility or exhaustion of COBRA coverage.
Individually Who Request an SBC

The plan must provide the requested SBC(s) as soon as practicable, but no later than seven business days after the request. Federal authorities say that a plan meets this deadline if it sends the SBC within seven business days. If the individual requests an SBC online, the SBC may be provided electronically.

COBRA Beneficiaries

The federal rules are clear that COBRA beneficiaries are entitled to receive an SBC during the plan’s open enrollment periods, too (remember that COBRA beneficiaries have the same rights as active employees to change coverage options, etc., during an open enrollment period). In most cases, COBRA coverage is “evergreen” in the sense that plan’s don’t require the COBRA beneficiary to affirmatively re-enroll during an open enrollment period. Thus, the plan would have to supply the SBC, for the option the COBRA beneficiary is currently enrolled in, not later than 30 days prior to the beginning of the new plan year.

Children Covered Under a Qualified Medical Child Support Order

Children who are covered under a plan pursuant to a qualified medical child support order should, we believe, be treated like an enrolling or re-enrolling employee. The better play here is probably to send the SBC to the child’s home, addressed to the child, or to the adult caring for the child (e.g., “in care of” the child).

E. When is an SBC Updated?

Plans must distribute an updated SBC at different times.

If the plan supplied an SBC to an individual during the enrollment process, but before the first day of coverage there is any change in the information required to be in the SBC, the plan must update and provide a current SBC no later than the first day of coverage. This may occur more frequently than you think. It may often be the case that by the time open enrollment commences, an updated (for the new plan year) SBC is not ready; in that case the plan will have to timely supply the current version of the SBC, but then supplement it with the new version of the SBC prior to the first day of the year.
In addition, if during the plan year the plan is materially amended in such a way that the information required to be in the SBC changes, the plan must supply an updated SBC or at least a notice of the change at least 60 days in advance of the effective date of the change. A “material” amendment is one that would be considered important by an average plan participant.

Happily, the final SBC regulations say the new 60-day rule does not apply to changes made at renewal. However, the timing rules for distributions of SBCs at open enrollment don’t do plan sponsors any favors either, and in some cases may require notice more than 60 days prior to the beginning of the plan year.

This obligation to supply notice of mid-year changes is a substantial acceleration of the deadline for supplying notice of material plan changes under current ERISA rules. Under ERISA guidelines, ERISA plans must distribute a notice of material modification within seven months after the close of the year in which the change is made, unless the change is a material reduction in benefits. In that case the notice must be supplied within 60 days after the change is adopted. As noted above, an updated SBC—or a notice of a change to the SBC (the notice must honor the style and format requirements of the SBC)—must be supplied not fewer than 60 days before the effective date of the change.

F. What Must the SBC Contain, Generally?

In Part II of this Guide we explore in substantial detail the precise rules regarding SBC content and formatting. Before we get to Part II, here’s a quick overview of the requirements, and some pragmatic nuts and bolts.

An Overview of the Content Requirements

The Labor Department’s final SBC regulations require the SBC to contain:

- A description of the coverage, including cost-sharing (deductibles, co-pays, coinsurance), as well as exceptions, reductions, and limitations of the coverage;
- An Internet address where the SBC may be obtained;
- Renewability and continuation of coverage provisions (e.g. COBRA rights);
Examples of coverage for maternity expenses and managing diabetes (the proposed regulations had required a third example, related to treatment of breast cancer; the agencies say they may add additional examples in the future);

A statement that the SBC is only a summary and that the plan documents should be consulted to determine the governing contractual provisions of the coverage;

A telephone number and Internet address for questions and how to obtain a copy of the plan document or the insurance contract, policy, or certificate;

An Internet address for obtaining a list of network providers and the prescription drug formulary; and

Beginning January 1, 2014, a statement about whether the plan provides “minimum essential coverage” for purposes of satisfying the individual health insurance mandate.

Model Documents

Federal authorities have posted updated versions of a model completed SBC, and SBC template (the updated versions are labeled “corrected on May 11, 2012” in the lower right corner of the first page). They are available at:

http://cciio.cms.gov/resources/other/index.html#sbcug

These documents replace the prior versions issued contemporaneously with the final regulations in February 2012.

Culturally and Linguistically Appropriate Standard (CLAS)

Plans must provide SBCs in a “culturally and linguistically appropriate manner.” If a participant resides in a county in which 10 percent or more of the population (according to the most recent census) is literate in the same non-English language, an offer (in that language) of oral translation assistance—and an offer to supply the SBC in that foreign language—must appear in a prominent place in the SBC. Federal authorities recommend the notice appear on the page of the SBC on which the “Your Rights to Continue Coverage” and “Your Grievance and Appeals Rights” sections appear.

Will an Intranet address suffice? It’s not clear that it does, but we assume that it does, at least with respect to individuals who have ready access to the Intranet site.
Appendix C includes a list of relevant counties, and model notice text—in Spanish, Chinese, Tagalog and Navajo—that plans may use to satisfy the culturally and linguistically appropriate notice requirement. Model SBCs and glossaries in Spanish, Chinese, Tagalog and Navajo are available at:


**Recommendation:** Where a plan must include a translation assistance notice, in a foreign language, in a prominent place on an individual’s SBC, it’s probably easiest to simply include the notice on all SBCs. For example, if an employer has 500 employees, and 250 reside in a county subject to the CLAS requirement, and 250 employees in an adjacent county that is not subject to CLAS, it’s nevertheless probably easiest to simply print the required CLAS notice on all the SBCs issued by the plan.

**Rigid Formatting Rules…but Some Exceptions, Particularly for Electronic SBCs**

As noted earlier, federal regulations don’t allow variations in style or formatting of a plan’s SBC, with very limited exceptions. One significant exception concerns electronically displayed SBCs, as a plan sponsor may display on an Internet or Intranet page.

Federal regulators permit minor adjustments to an SBC’s formatting to accommodate the plan’s information and electronic display method, such as expansion of columns. Additionally, it is permissible to display the SBC electronically on a single webpage, so the viewer can scroll through the information required to be in the SBC without having to advance through pages (as long as a printed version is available that meets the formatting requirements of the SBC). However, the deletion of columns or rows is not permitted when displaying a complete SBC.

In addition, plans may display SBCs, or parts of SBCs, in a way that facilitates comparisons of different benefit package options by individuals considering their coverage choices. For example, on a website, viewers could be allowed to select a comparison of only the deductibles, out-of-pocket limits, or other cost sharing of several benefit package options. This could be achieved by providing the “deductible row” of the SBC for several benefit packages, but without having to repeat the first one or two columns, as appropriate, of the SBC for each of the benefit packages.

However, such a chart, website, or other comparison does not, itself, satisfy the requirements to provide the SBC. The full SBC for all the benefit options included in the comparison view/tool must be made available in accordance with the regulations and other guidance.
Combining Multiple Partial SBCs into a Single SBC, or Supplying Multiple Partial SBCs in Lieu of a Single SBC

A plan whose benefits are supplied by two or more insurers, each of which supplies a partial SBC (reflecting the insurers’ respective pieces of the larger plan) may take those partial SBCs and combine the information into a single SBC.

What about simply taking separate SBCs (whether partial or complete) supplied by various carve-out vendors, and giving the several SBCs to covered or eligible individuals in lieu of a single, comprehensive SBC? For the first year of the SBC requirements, federal authorities permit a plan that uses two or more insurers to provide multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements. In such circumstances, the plan administrator should take steps (such as a cover letter or a notation on the SBCs themselves) to indicate that the plan provides coverage using multiple different insurers and that individuals who would like assistance understanding how these products work together may contact the plan administrator for more information.

It’s not entirely clear whether this special accommodation for supplying several partial SBCs applies where one or more of the benefits so summarized are self-insured, but a plan may get away with doing so. The accommodation is only for the first year, and federal authorities are largely taking a “hands off” enforcement approach for the first year, as long as the plan is making a good faith effort to comply.

Expressing Carve-Out Arrangements in a Plan’s SBC

If a health plan utilizes “carve-out arrangements” (such as pharmacy benefit managers and managed behavioral health organizations) to help manage certain benefits, federal authorities expect the party responsible for issuing the SBC to make an effort to include all relevant information, even though the authorities recognize some of the required information may be in the hands of other parties. “Do your best” is the standard, at least for the first year (or perhaps two) of the SBC requirement.

A special temporary rule allows plans that use multiple insurers to supply benefits under a single plan to actually issue multiple partial SBCs that, taken together, satisfy all the SBC requirements. Due to the administrative challenges of combining benefit information related to benefits supplied by different vendors, during the first year of the SBC requirements the federal authorities give a little slack to plans that use two or more insurers to supply benefits under the plan. The authorities will consider the provision of multiple partial SBCs that, together, provide all the relevant information to meet the SBC requirements.
content requirements. In such circumstances, the plan administrator should take steps (such as a cover letter or a notation on the SBCs themselves) to indicate that the plan provides coverage using multiple different insurers and that individuals who would like assistance understanding how the different insured products work together may contact the plan administrator for more information (and provide the contact information).

**Expressing FSA, HRA or HSA Reimbursements, and Wellness Program Rewards or Penalties, in an SBC**

If an employer offers reimbursement programs such as a health FSA, a health reimbursement program or health savings account to enrollees in a medical plan, and permits the benefits under these accounts or programs to reduce cost sharing under the medical plan, the plan is permitted to combine information for all of these accounts and programs, and reflect them in a single SBC, as long as the SBC remains understandable. The same is true for wellness program credits or surcharges.

For example, the cost sharing implications of an employer-provided reimbursement program may be denoted in the SBC, where the SBC speaks to deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. Or the SBC may reflect potential adjustments in these amounts due to wellness program participation.

In these cases, the coverage examples in the SBC should note the assumptions used in creating them (the federal authorities’ sample completed SBC includes an example of how to denote the effects of a diabetes wellness program).

**Multiple Coverage Tiers**

Group plans typically offer an employee a choice, under each coverage option, between multiple coverage tiers (e.g., employee-only coverage, employee-plus-one coverage, employee-plus-family coverage, etc.).

Plans are not required to supply or make available to an individual a separate SBC for each coverage tier. Plans may combine information for different coverage tiers in one SBC, provided the appearance is understandable. The SBC’s coverage examples should be completed using the cost-sharing features (e.g., deductible and out-of-pocket limits) for the employee-only coverage tier and the coverage examples should note this assumption.
Multiple Deductible and Out-of-Pocket Expense Maximums

Some plans permit participants to select the deductible, copayment and co-insurance levels for a particular benefit option. In this case, the plan is not required to provide a separate SBC for every possible combination that a participant may select under that option. The plan may combine information for different cost-sharing selections (such as levels of deductibles, copayments, and co-insurance) in a single SBC, provided the SBC’s appearance is understandable. This information may be presented in the form of options, such as deductible options and out-of-pocket maximum options. In these circumstances, the SBCs coverage examples (more on these in Part II) should note the assumptions used in creating them. An example of how to note assumptions used in creating coverage examples is provided in the sample completed SBC prepared by federal authorities.

Combining the SBC with the SPD, or Using a Cross-Reference to the SPD to Satisfy an SBC Requirement

SBCs may be provided either on a stand-alone basis or as part of the summary plan description (SPD) if certain requirements are met. If the SBC is provided as part of the SPD, all of the SBC’s pages must remain intact and must be prominently displayed at the beginning of the materials (such as immediately after a table of contents). Even though the SBC may be part of the SPD, the timing requirements for providing the SBC must be met.

Note that there are other differences between the rules for providing SPDs and SBCs. These include the fact that SPDs are required to be furnished only to covered participants, while the SBC must be furnished to participants and beneficiaries (i.e., dependents), although furnishing the SBC to the participant will normally be deemed to accomplish delivery to dependents.

Although an SBC may be combined in an SPD, it is not adequate to simply refer to the SPD as a way to satisfy a required SBC content element. For example, the SBC can’t say, “See the deductible description in the SPD” in lieu of actually describing the deductible, in the SBC. However, an SBC may include a reference to the SPD in the SBC footer. For example, a footer on the SBC could say, “Questions: Call 1-800-[insert] or visit us at www.[insert].com for more information, including a copy of your plan's summary plan description.”
In addition, an SBC that includes all required SBC elements may include reference to specified pages or portions of the SPD in order to supplement or elaborate on that information.

**Tinkering with Headers and Footers in the SBC**

A plan may make certain changes to the SBC template. For example, a plan may include the header only on the first page of the SBC. In addition, it may include the footer only on the first and last pages of the SBC, instead of on every page.

The plan may add barcodes or control numbers to the SBC for quality control purposes.

**Making Minor Adjustments to the SBC Format, such as Changing Row and Column Sizes, Carrying Over Information from One Page to Another, etc.**

Although prohibited by the formal SBC template instructions, federal authorities (in a series of FAQs regarding SBCs) say they’ll permit minor adjustments to an SBC’s row or column size in order to accommodate the plan's information, as long as the information is understandable. The deletion of columns or rows is not permitted.

Rolling over information from one page to another is permitted.
PART II: BUILDING AND REVIEWING AN SBC

On the pages that follow we take a much more detailed look at how an SBC is required to look, and what it is required to include. For each page in the federal authorities’ model SBC, we have attached several screen shots, with instructions regarding content and formatting requirements. Following these screen shots is a sample, completed page of the SBC.

For example, below you’ll find 14 separate screen shots of page one of the SBC template, and call-out boxes indicating the rules regarding content and formatting. Following those 14 pages is a sample completed page one of an SBC. Following that are several screen shots of page two of the SBC template, and so on.

Note: The federal authorities’ SBC template is six pages, but its sample completed SBC reflects eight pages. You’ll see below, where we refer to the template and its instructions, that we indicate which of the six pages in the template we’re dealing with, but we include all eight pages of the sample completed SBC.

In certain places on the pages that follow we’ve shown model text in red, bold-faced text. We’ve done this simply for emphasis. The SBC is not required to use red, bold-faced text.
1. **Top, left header:** Insert the plan name and, after the colon, the name of the plan sponsor or insurance company (these entries may be reversed). Both entries should be in 16 point font and **bold type.** Use the commonly known company name. The plan sponsor and insurance company have the option to use their logo instead of typing in their names. **NOTE:** DOL FAQs clarify that a plan may choose to include the header only on the first page of the SBC, and may choose to include the footer only on the first and last page of the SBC.

The federal OMB control numbers (displayed on the SBC template issued by federal authorities) should not be displayed on SBCs provided by plans to enrollees. A plan’s own control number or barcode may be added.

2. **Top right, after "Coverage Period":** Show the beginning and end dates for the applicable coverage period (plan year or policy year) in the following format: MM/DD/YYYY. For example, "Coverage Period: 01/01/2013 – 12/31/2013."

If the SBC is being provided mid-year as a notice of material modification (SMM) to the plan—summarizing a material change to the plan—the plan must show the beginning and end dates of the period (during the plan or policy year) for which the modification is effective. For example, "Coverage Period: 03/15/2013 – 12/31/2013."

3. **Be sure you use a current version of the SBC template.** The most up-to-date version issued prior to release of this Guide was issued on May 11, 2012.
4. "This is only a summary": This disclaimer should be copied. The plan may not vary the font size, graphic or formatting. The plan should insert a website or phone number for accessing or requesting copies of the policy or plan documents. It’s not clear whether this must be an Internet site or could be an Intranet site; the answer may depend on just how “accessible” the SBC is via the Intranet site.

The plan should also include a website and telephone number for accessing or requesting copies of the Uniform Glossary (Note: the Uniform Glossary may be accessed at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov. One or both of these websites may be designated for purposes of obtaining the Uniform Glossary).

5. After "Coverage for": Indicate who the coverage is for (such as Individual, Individual + Spouse, Family). Use the terms used in the policy or plan document to describe coverage tiers.

After "Plan Type": Indicate the type of coverage, such as HMO, PPO, POS, Indemnity or High Deductible Health Plan. Labels inserted here may be generic, e.g., "Standard Option," "High Option," etc. Again, use the nomenclature used by the plan.
6. "Important Questions" Chart—This chart must always appear on page 1 and the rows must always appear in the same order.

7. "Answers" column: If there is a different amount for in-network and out-of-network expenses (such as annual deductible, additional deductibles, or out-of-pocket limits) list both amounts, using the terms to describe provider networks used by the plan. For example, if the plan uses the terms "preferred provider" and "non-preferred provider" and the annual deductible is $2,000 for a preferred provider and $5,000 for a non-preferred provider, then the Answers column should show $2,000 preferred provider, $5,000 non-preferred provider.

8. "Why this Matters" column: Plans must duplicate the language given for the "Why This Matters" box exactly, and may not alter the language.
9. "What is the Overall Deductible?" – “Answers” column: If there is no overall deductible, answer "$0". If there is an overall deductible, answer with the dollar amount of the deductible. If the deductible is not annual, indicate the period of time that the deductible applies.

We've shown model text in red, bold-faced text. We've done this simply for emphasis. The SBC is not required to use red, bold-faced text.

If there is an overall deductible, underneath the dollar amount plans must (1) specify major categories of covered services that are not subject to the deductible (for example: "Does not apply to preventive care and generic drugs"), and (2) include language listing major exceptions, such as out-of-network co-insurance, deductibles for specific services and copayments, which do not count toward the deductible (for example: “Out-of-network co-insurance and copayments don’t count toward the deductible”).

For family coverage which has a separate deductible amount for each individual and the family, show both the individual deductible and the family deductible. For example, "$2,000 person/$3,000 family.”
10. "What is the overall deductible?" – "Why this Matters" column: If there is no overall deductible, insert the following: "See the chart starting on page 2 for your costs for services this plan covers."

If there is an overall deductible, insert the following: "You must pay all the costs up to the deductible amount before this plan begins to pay for the covered services you use. Check your 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."

We've shown model text in red, bold-faced text. We've done this simply for emphasis. The SBC is not required to use red, bold-faced text.
11. “Are there other deductibles for specific services?” – “Answers” column: If the overall deductible is the only deductible, answer “No.”

If there are other deductibles, answer “Yes”, then list the names and deductible amounts of the three most significant deductibles other than the overall deductible. Significance of deductibles is determined based on two factors: probability of use and financial impact on an individual. Examples include deductibles for prescription drugs and in-patient hospital care. For example: “Yes, $2,000 for prescription drug expenses and $2,000 for in-patient hospitalization.”

If the plan has more than the three other deductibles, and not all of them are shown, the following statement must appear at the end of the list of the three most significant other deductibles: “There are other specific deductibles.” If the plan has fewer than three other deductibles, the following statement must appear at the end: “There are no other specific deductibles.”

If portraying family coverage for which there is a separate deductible amount for each individual and the family, show both the individual and family deductible. For example: “Prescription drugs – Individual $200, Family $500.”

We’ve shown model text in red, bold-faced text. We’ve done this simply for emphasis. The SBC is not required to use red, bold-faced text.
12. “Are there other deductibles for specific services?” – “Why this Matters” column: If there are no other deductibles, insert the following language: “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.”

If there are other deductibles, insert the following language: “You must pay all of the costs for these services up to the specific deductible amount before the plan begins to pay for these services.”

We’ve shown model text in red, bold-faced text. We’ve done this simply for emphasis. The SBC is not required to use red, bold-faced text.
13. **“Is there an out-of-pocket limit on my expenses?”** – **“Answers” column:** If there are no out-of-pocket limits, respond “No.”

If there is an out-of-pocket limit, respond “Yes,” along with a specific dollar amount that applies in each coverage period. *For example:* “Yes. $5,000.”

If portraying family coverage, and there is a single out-of-pocket limit for each individual and a separate out-of-pocket limit for the family, show both the individual out-of-pocket limit and the family out-of-pocket limit. *For example:* “Individual $1,000/Family $3,000.”

If there are separate out-of-pocket limits for in-network providers and out-of-network providers, show both the in-network out-of-pocket limit and the out-of-network out-of-pocket limit. Plans and insurers should use the terminology in the plan document (e.g., in-network, participating or preferred provider). *For example:* “For participating providers $2,500 person/$5,000 family; For nonparticipating providers $4,000 person/$8,000 family.”

We’ve shown model text in **red, bold-faced text.** We’ve done this simply for emphasis. The SBC is not required to use red, bold-faced text.
"Is there an out-of-pocket limit on my expenses?" – "Why this Matters" column: If there is an out-of-pocket limit, insert the following language:"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 healthcare expenses."

If there is no out-of-pocket limit, insert the following language: "There’s no limit on how much you could pay during a coverage period for your share of the cost of covered services."

We’ve shown model text in **red, bold-faced text.** We’ve done this simply for emphasis. The SBC is not required to use red, bold-faced text.
15. “What is not included in the out-of-pocket limit?” — “Answers” column: If there is no out-of-pocket limit, indicate “This plan has no out-of-pocket limit.”

If there is an out-of-pocket limit, the plan must list any major exceptions. The list must always include the following three terms: premiums, balance-billed charges (unless balance billing is prohibited), and healthcare the plan doesn’t cover. Depending on the plan, the list could also include: co-payments, out-of-network co-insurance, deductibles, and penalties for failure to obtain pre-authorization for services. The plan must state that these items do not count toward the limit. For example: “Co-payments, premiums, balance-billed charges and healthcare this plan doesn’t cover.”

16. “What is not included in the out-of-pocket limit?” — “Why this Matters” column: If there is an out-of-pocket limit, the plan must show the following language: “Even though you pay these expenses, they don’t count toward the out-of-pocket limit.”

If there is no out-of-pocket limit, state “Not applicable because there’s no out-of-pocket limit on your expenses.”

We’ve shown model text in red, bold-faced text. We’ve done this simply for emphasis. The SBC is not required to use red, bold-faced text.
17. “Is there an overall annual limit on what the plan pays?” — “Answers” column: The plan should respond “Yes” or “No” based on whether the plan has an overall annual limit.

If the answer is “Yes,” the plan should include a brief description and dollar amount of the overall annual limit. For example: “Yes, $2 million.” (Note that annual dollar limits on “essential health benefits” are largely prohibited after 2010, and completely prohibited after 2013).

If the plan does not have an overall annual limit, the plan should state “No.”

18. “Is there an overall annual limit on what the plan pays?” — “Why this Matters” column: If there is an overall annual limit, the plan must indicate the following: “This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You’re responsible for all expenses above this limit. The chart on page 2 describes specific coverage limits, such as limits on the number of office visits.”

If there is no overall annual limit, the plan must indicate the following: “The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.”

We’ve shown model text in red, bold-faced text. We’ve done this simply for emphasis. The SBC is not required to use red, bold-faced text.
19. "Does this plan use a network of providers?" – "Answers" column: If this plan does not use a network, the plan must respond, "No."

If the plan does use a network, the plan must respond, "Yes," and include information on where to find a list of preferred providers or in-network providers. For example: "Yes. For a list of preferred providers, see www.[insert].com or call 1-800-[insert]." Plans should use the terminology in the policy or plan document (e.g., network, participating or preferred provider, etc.).

20. "Does this plan use a network of providers?" – "Why this Matters" column: If the plan uses a network, the plan must show the following language: "If you use an in-network doctor or other healthcare 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."

If the plan does not use a network, the plan must show the following language: "This plan treats providers the same in determining payment for the same services."

We've shown model text in red, bold-faced text. We've done this simply for emphasis. The SBC is not required to use red, bold-faced text.
21. "Do I need a referral to see a specialist?" — "Answers" column: Plans should use plan-specific language with respect to specialists. For example, distinguishing between preferred and non-preferred specialists or in-network and out-of-network specialists.

Plans should specify whether written or oral approval is required to see a specialist.

Plans should specify whether specialist approval is different for different plan benefits.

22. "Do I need a referral to see a specialist?" — "Why this Matters" column: If a referral is required in order for the plan to cover services provided by specialists, the plan must insert the following language: "This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan’s permission before you see the specialist."

If there is no referral required, the plan must insert the following language: "You can see the specialist you choose without permission from the plan."

We’ve shown model text in red, bold-faced text. We’ve done this simply for emphasis. The SBC is not required to use red, bold-faced text.
23. “Are there services this plan doesn’t cover?” – “Answers” column: If there are any items or services the plan doesn’t cover the plan should answer “Yes.” (A “No” answer should be inserted only if the plan covers all items and services without any exclusions or limitations, including any limitations based on medical necessity.)

24. “Are there services this plan doesn’t cover?” – “Why This Matters” column: If there are no excluded services shown in the “Services Your Plan Doesn’t Cover” box on page 3 or 4 of the SBC, then the plan must show the language: “See your plan document for information about excluded services.”

If there are excluded services shown in the “Services Your Plan Does Not Cover” box on page 3 or 4 of the SBC, then the plan must show the following language: “Some of the services this plan doesn’t cover are listed on page [3 or 4]. See your plan document for additional information about excluded services.” The plan should insert the correct page (3 or 4) depending on where the “Services Your Plan Does Not Cover” box appears in the SBC.

We’ve shown model text in red, bold-faced text. We’ve done this simply for emphasis. The SBC is not required to use red, bold-faced text.
### Employer's Guide to the Summary of Benefits and Coverage

#### SAMPLE COMPLETED SBC—PAGE 1

**Insurance Company 1: Plan Option 1**  
*Coverage Period: 01/01/2013 - 12/31/2013*

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$500 per person / $1,000 family</td>
<td>You must pay all the costs up to the deductible amount before the 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.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes, $300 for preventive care services. There are no other specific deductibles.</td>
<td>You must pay all the costs for these services up to the specific deductible amount before the plan begins to pay for these services.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For participating providers: $2,500 per person / $6,000 family. For non-participating providers: $4,000 per person / $8,000 family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance billed charges, and health care plan deductibles.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 3 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www">www</a>. [insert].com or call 1-800-[insert] for a list of participating providers.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the cost of covered services. Be sure to use in-network doctors or hospital inpatient or participating providers in their network. See the chart starting on page 2 for how this plan pays different kinds of procedures.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don’t need a referral to see a specialist.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>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.</td>
</tr>
</tbody>
</table>

*If you want to know about any of the underlined terms used in this form, see the Glossary. You can view the Glossary by calling 1-800-[insert] or visiting www. [insert]. To request a copy, call 1-800-[insert].*
1. **Cost Sharing Information Box**: The first three bullets in this box should be duplicated with the same text, formatting, graphic, bolded words, and bullet points. Only the fourth bullet may change.

2. **Cost Sharing Information Box**: The fourth bullet will change depending on the plan. For plans that use a network, the plan should fill in the blank on the fourth bullet using the terminology that the plan uses for "in-network" or "preferred provider." This should be the same term used in the heading of the first sub-column under the *Your Cost* column.

   For non-network plans, the plan should delete the fourth bullet and replace it with: "*Your cost sharing does not depend on whether a provider is in a network.***

We've shown model text in **red, bold-faced text**. We've done this simply for emphasis. The SBC is not required to use red, bold-faced text.
3. **Chart Starting on Page 2:** This chart must always begin on page 2, and the rows shown on pages 2 and 3 must always appear in the *same order*. However, the rows shown on page 2 may extend to page 3 if space requires, and the rows shown on page 3 may extend to the beginning of page 4 if space requires. The heading of the chart *must* appear on the *top* of all pages used. (See Part I of this Guide for special accommodations regarding formatting, where SBCs are *displayed* online; but the formal SBC that is supplied to eligible or enrolled individuals must meet the formatting requirements described in this Part II).

4. **"Your Costs" columns:** Indicate the participant’s costs for the services needed if they use an in-network provider and if they use an out-of-network provider for each of the services listed. Plans may vary the number of columns depending on the types of coverage and the number of preferred provider networks. Most plans that use a network should use two columns, although some plans with more than one level of in-network provider may use three columns. Non-network plans may use one column.

   Plans should insert the terminology used in the plan document to title the columns. *For example,* the columns may be called “In-network” and “Out-of-network” or “Preferred Provider” and “Non-Preferred Provider” based on the terms used in the plan. *The sub-headings should be deleted for non-network plans with only one column.*

   The columns should appear from left to right, from most generous cost sharing to least generous cost sharing. *For example,* if a 3-column format is used, the columns might be labeled (from left to right) “In-Network Preferred Provider,” “In-Network Provider” and then “Out-of-Network Provider.”
5. **“Your Cost” columns:** For HMOs providing no out-of-network benefits, the plan should insert “Not covered” in all applicable boxes under the far-right subheading under the “Your Cost” column (which, for coverage providing out-of-network benefits, would usually be the out-of-network provider or non-preferred provider column).

Plans must complete the responses under these sub-headings based on how the plan covers the specific services listed in the chart. Fill in the “Your Cost” column(s) with the co-insurance percentage, the co-payment amount, **“No charge”** if the employee pays nothing or **“Not covered”** if the service is not covered by the plan. When referring to co-insurance, include a percentage valuation. For example, “20% co-insurance.” When referring to co-payments, include a per occurrence cost. For example: “$20/visit or $15/prescription.”

Refer to the specific additional instructions for details on completing the “Your Costs” columns in the chart for the following common medical events: If you visit a healthcare provider’s office or clinic; if you need drugs to treat your illness or condition; and if you have mental health, behavioral health or substance abuse needs.
6. **“Limitations & Exceptions” column**: In this column, list the significant limitations and exceptions for each row. Significance of limitations and exceptions is determined by the plan based on two factors: probability of use and financial impact on the individual. Examples include, but are not limited to, limits on the number of visits, limits on specific dollar amounts paid by the plan, prior authorization requirements, unusual exceptions to cost sharing, lack of applicability of a deduction or a separate deductible, etc.

Each limitation or exception should specify dollar amounts, service/visit/treatment limitations and annual maximums, if applicable. Language should be formatted as follows: “Coverage is limited to $XXX/visit and $XXX annual max” or “No coverage for XXXX.” (Note that lifetime dollar limits on “essential health benefits” are prohibited after 2010 (generally speaking) and annual dollar limits on these benefits are mostly prohibited after 2010 (generally speaking) and completely prohibited for plan years beginning in 2014.)

If a plan requires the participant or beneficiary to pay 100% of a service received in-network, then that should be considered an “excluded service” and should appear in the “Limitations & Exceptions” column and also appear in the “Services Your Plan Does Not Cover” box on page 3 or 4 of the SBC. For example, coverage that excludes services in-network, such as habilitation services, prescription drugs or mental health services, must show those exclusions in both the “Limitations & Exceptions” column and the “Services Your Plan Does Not Cover” box.

If there are pre-authorization requirements, the plan must show the requirement, including specific information about the penalty for noncompliance.
7. **“Limitations & Exceptions” column**: For each Common Medical Event in the chart, the plan has the discretion to merge the boxes in the “Limitations & Exceptions” column and display one response across multiple rows if such a merger would lessen the need to duplicate comments and would save space.

8. **“Limitations & Exceptions” column**: If there are no items that need to appear in the “Limitations & Exceptions” column, the plan should show “—none—.”

---

We’ve shown model text in **red, bold-faced text**. We’ve done this simply for emphasis. The SBC is not required to use red, bold-faced text.
9. "If you visit a healthcare provider’s office or clinic": If the plan covers other practitioners’ care (which includes chiropractic care and/or acupuncture), in the “Other practitioner office visit” row, provide the cost sharing for the other practitioners’ care in the “Your Cost” columns. For example, under the in-network column, you should insert “20% co-insurance for chiropractor and 10% co-insurance for acupuncture,” as appropriate.

If the plan does not cover other practitioners’ care, the plan should insert “Not Covered” in the “Your Cost” columns for “Other practitioner office visit.”
10. “If you need drugs to treat your illness or condition”: Under the “Services You May Need” column, the plan should list and complete the categories of prescription drug coverage under the plan. For example, the plan might fill out 4 rows with the terms “Generic drugs,” “Preferred brand drugs,” “Non-preferred brand drugs” and “Specialty Drugs.” The plan should avoid the terms “tiers” and instead use “categories” as it is more easily understood by consumers.

Under the “Your Cost” column, plans should include the cost sharing for both retail and mail order drugs.

11. “More information about prescription drug coverage...”: Under the “Common Medical Events” column, provide a link to the website location where the participant can find more information about prescription drug coverage for this plan. If there is no website, provide a contact phone number where the participant can receive more information about prescription drug coverage for this plan.
12. "If you have outpatient surgery": If there are significant expenses associated with a typical outpatient surgery that have higher cost sharing than the facility fee or physician/surgeon fee, or are not covered, then they must be shown under the "Limitations & Exceptions" column. Significance of such expenses is determined by the plan based on two factors: probability of use and financial impact on the participant or beneficiary. For example, a plan might show that the cost-sharing for the physician fee row is "20% co-insurance," but the "Limitations & Exceptions" column might show "Radiology 50% co-insurance."
### Sample Completed SBC—Page 2

**Insurance Company 1: Plan Option 1**

**Summary of Benefits and Coverage**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider in an office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$35 copay/visit</td>
<td>$40 coinsurance</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Specialty visit</td>
<td>$100 copay/visit</td>
<td>$100 coinsurance</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Other practitioners office visit</td>
<td>$75 copay/visit</td>
<td>$75 coinsurance for chiropractic and acupuncture</td>
<td>--</td>
</tr>
<tr>
<td>Preventive care / screening / immunization</td>
<td>Preventive care / screening / immunization</td>
<td>No charge</td>
<td>$40 coinsurance</td>
<td>--</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (pap, blood work)</td>
<td>$10 copay/test</td>
<td>$40 coinsurance</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT, PET scans, MRI)</td>
<td>$100 copay/test</td>
<td>$100 coinsurance</td>
<td>--</td>
</tr>
</tbody>
</table>

---

*Questions: Call 1-800 [insert] or visit at [insert].
If you aren’t clear about any of the information used in this form, see the Glossary. You can view the Glossary at [insert] or call 1-800 [insert] to request a copy.*
1. "If you have a hospital stay": If there are significant expenses associated with a typical hospital stay that has higher cost sharing than the facility fee or physician/surgeon fee, or are not covered, then that must be shown under the "Limitations & Exceptions" column. Significance of such expenses is determined by the plan based on two factors: *probability of use and financial impact on the participant*. For example, a plan might show that the cost sharing for the facility fee is "20% co-insurance," but the "Limitations & Exceptions" column might show "Anesthesia 50% co-insurance."

2. "If you have mental health, behavioral health, or substance abuse needs": If the cost sharing differs for outpatient services for mental/behavioral health needs or substance abuse needs depending on whether the services are office visits or are other outpatient services, show the cost sharing for each. *For example*, a plan might show that the cost sharing for Mental/Behavioral health outpatient services is "$35 co-pay for office visits and 20% co-insurance other outpatient services."
### Excluded Services & Other Covered Services:

"Excluded Services and Other Covered Services": This section may appear on page three or four of the SBC, depending on the length of the chart starting on page two of the SBC, but it must always follow immediately after the chart starting on page two of the SBC.

Each plan must place all services listed below in either the "Services Your Plan Does Not Cover" box or the "Other Covered Services" box according to the plan’s provisions. The required list of services includes:

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

The list must be in alphabetical order. The lists must use bullets next to each item.

Other benefits may be added to the "Services Your Plan Does Not Cover" box. If services appear in the "Limitations & Exceptions" column in the chart starting on page two because the plan requires the participant to pay 100% of the service in-network, those services should also appear in the "Services Your Plan Does Not Cover" box.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$10 copay/ prescription (mail and mail order)</td>
<td>40% coinsurance</td>
<td>Covers up to a 30-day supply (mail prescription), 31-90 day supply (mail order prescription)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>20% coinsurance (mail and mail order)</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>40% coinsurance (mail and mail order)</td>
<td>60% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>50% coinsurance</td>
<td>70% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have an outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need inpatient medical attention</td>
<td>Emergency room</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>
### 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)**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services 35 copay/office visit and 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services 50 coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services 35 copay/office visit and 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services 50 coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skills training 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice care 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>$35 copay/visit</td>
<td>Not Covered</td>
<td>Limited to one exam per year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glasses 20% coinsurance</td>
<td>Not Covered</td>
<td>Limited to one pair of glasses per year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>No Charge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Questions: Call 1-800-[insert] or visit us at [www.[insert]]. If you aren’t sure about any of the undefined 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.*

4 of 8
1. "Other Covered Services": The plan may not add any other benefits to the "Other Covered Services" box other than the benefits listed on the previous page. The list must be in alphabetical order. The list must use bullets next to each item.

Instead of summarizing coverage for items and services provided outside the U.S., the plan may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the U.S. This statement should appear in the "Other Covered Services" box. For example, "Coverage provided outside the U.S. See www.[insert].com/expatriate." (Note that expatriate plans are excused from SBC compliance for the first year of the SBC rules’ applicability.)

If the plan provides limited coverage for any of the services listed above, the limitation must be stated in the "Services Your Plan Does Not Cover" box or in the "Other Benefits Covered" box, but not both. For example, if a plan provides acupuncture in limited circumstances, the plan could choose to include the prescribed statement in the "Services Your Plan Does Not Cover" box: "Acupuncture, unless it is prescribed by a physician for rehabilitation purposes." Alternatively, the required statement could be in the "Other Covered Services" box, as follows: "Acupuncture, if it is prescribed by a physician for rehabilitation purposes."
2. “Your Rights to Continue Coverage”: The following language must appear without change.

“If you lose coverage under the plan, then, depending upon the circumstance, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov”
3. **Your Grievance and Appeals Rights**: This section must appear. Contact information should be inserted as follows (more than one of these instructions may be applicable):

For group health coverage subject to ERISA, insert applicable plan contact information. Also insert contact information for the Department of Labor’s Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If coverage is insured, also insert the applicable State Department of Insurance contact information.

For non-federal governmental group health plans and church plans that are group health plans, insert contact information for member assistance provided by any third-party administrator that is hired by or contracts with the plan, and, if available, consumer assistance offered directly by the plan such as applicable member services, employee services, Human Relations or Fiscal and Personnel Department or consumer support services. If coverage is insured, also insert the applicable State Department of Insurance (DOI) contact information.

If applicable in your state insert: "**Additionally, a consumer assistance program can help you file your appeal. Contact [insert contact information]. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html**"
4. "Language Access Services": The SBC must be presented in a "culturally and linguistically appropriate manner."

These rules provide that, with respect to covered individuals residing in specified counties of the U.S., plans must make available interpretive services, and upon request must provide written translations of the SBC in four non-English languages (Spanish, Tagalog, Chinese and Navajo). For covered individuals residing in such counties, English versions of the SBC must disclose, in the relevant non-English language, the availability of translation services.

The counties with respect to which this must be done are those which, according to the most recent census, at least 10 percent of the population residing in the county is literate only in the same non-English language. A chart showing these counties is attached at Appendix C.

The plan must insert the telephone number to which a request for a translated SBC may be made.
**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.)**

- Cosmetic surgery
- Dental care (Adult)
- Intensive care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine care (Adult)
- Routine foot care

**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.)**

- Acupuncture (if prescribed for inpatient rehabilitation purposes)
- Chiropractic care
- Dietetic care
- General surgery
- Group dental
- Group vision
- Most coverage provided outside the United States; see www.jan.org/janintl
- Weight loss programs

Questions? Call 1-800-JANES or visit www.jan.org.
If you aren’t clear about any of the undelineed information in this form, see the Glossary. You can view the Glossary at www.jan.org or call 1-800-JANES to request a copy.
Insurance Company 1: Plan Option 1

Your Rights to Continue Coverage:

**Individual health insurance sample—**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. These are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering coverage in the state
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer [contact name]. You may also contact your state insurance department [insert applicable State Department of Insurance contact information].

**Group health coverage sample—**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium which may be significantly higher than the premium you pay while covered under the plan. Further information on your rights to continue coverage may be found at:

For more information on your rights to continue coverage, contact the plan [contact name]. You may also contact your state insurance department, the U.S. Department of Labor, Employees Benefits Security Administration at 1-866-444-3372 or www.dol.gov/esa, or the U.S. Department of Health and Human Services at 1-877-260-4202 or www.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you must be able to appeal or file a grievance. For questions about your right to appeal, the notice, or a grievance, you can contact [insert applicable contact information from insurance].

To see examples of how this plan might cover care for a sample medical situation, see the next page.

Questions? Call 1-800-[insert] or visit us at www.[insert].

If you aren’t clear about any of the undefined 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.
1. "Sample care costs": The Department of Health and Human Services has provided standardized data to be used in the "Sample care costs" section for the coverage examples. The plan must leave the "Sample care costs" section as is (i.e., leave the numbers alone!). As it says on the left, these numbers are not intended to estimate the participant's actual costs under the plan. How the plan pays these sample care costs will be customized by the plan (see Box 2). Note that the "Amount owed to providers" at the top of the column must equal the "Total" at the bottom of the "Sample care costs" box.

2. "Patient pays": Here the plan applies its own unique cost sharing and benefit features based upon the cost sharing and benefit features of the plan for which the SBC is being created to complete the "Patient pays" section. HHS provides calculators to assist the plan in completing this information, including underlying detail such as the date of service, service code, provider type, category, descriptive notes for identifying the specific service provided, and allowed amounts. These calculations should be made using the order in which the services are said to be provided (in the HHS data).
   - Deductible – Includes everything the participant pays up to the deductible amount. Any co-pays that accumulate toward the deductible are accounted for in this cost sharing category, rather than under the "co-pays" heading.
   - Co-pays – Those co-pays that do not apply to the deductible.
   - Co-insurance – Anything the participant pays above the deductible that's not a co-pay or non-covered service. This should be the same figure as the Total less the Deductible, Co-pays and Limits or Exclusions.
   - Limits or Exclusions – Anything the participant pays for non-covered services that exceed plan limits.

Additional information that must be included in, or inserted below, the "Patient pays" box is described on the following page.
3. “Amount owed to providers,” “Plan pays,” and “Patient pays” – Each plan must calculate and populate the “Plan pays” amount at the top of the column by subtracting the “Patient pays” total (Box 4) from the “Amount owed to providers” total at the top of the columns (the “Amount owed to providers” at the top of the column must equal the “Total” at the bottom of the “Sample care costs” box). If all the costs associated with the “Coverage Examples” are excluded under the plan, the phrase “This condition is not covered, so patient pays 100%” is added after the “Patient pays” amount at the top of the column. Otherwise no narrative should appear after the “Patient pays” amount.

4. If the plan has a wellness program that varies the deductibles, co-payments, co-insurance or coverage for any of the services listed in a treatment scenario, the plan must complete the calculations for that treatment scenario assuming that the patient is participating in the wellness program. Additionally, the plan must also include a box below the coverage example with the following language (and appropriate contact information):

- **For pregnancy** – Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: [insert].
- **For diabetes** – Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact [insert].

5. “This is not a cost estimator”: This text box must appear precisely as shown in the template.

We've shown model text in **red, bold-faced text**. We've done this simply for emphasis. The SBC is not required to use red, bold-faced text.
### Insurance Company 1: Plan Option 1

**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.

**About these Coverage Examples:**

- **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:** $6,400
- **Patient pays:** $1,140

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Medication</td>
<td>$500</td>
</tr>
<tr>
<td>Laboratory test</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccine, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$7,540</td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$700</td>
</tr>
<tr>
<td>Copay</td>
<td>$30</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1520</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,140</td>
</tr>
</tbody>
</table>

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

- **Amount owed to providers:** $6,400
- **Plan pays:** $5,600
- **Patient pays:** $880

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription</td>
<td>$2,000</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,500</td>
</tr>
<tr>
<td>Office Visit and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory test</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,400</td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$600</td>
</tr>
<tr>
<td>Copay</td>
<td>$500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$500</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,880</td>
</tr>
</tbody>
</table>

*Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact [insert].*
1. “Questions and answers about the Coverage Examples”: Plans must include this page as it appears and not alter the text, font, graphic, shading, etc. This section should be placed immediately following the “Coverage Examples.”
APPENDIX A—SBC DELIVERY GRID

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<th>Notes</th>
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<tbody>
<tr>
<td><strong>Current Enrollees (including COBRA enrollees)</strong></td>
<td>At open enrollment: With open enrollment materials, if must affirmatively re-enroll or re-enrollment is evergreen but individual may select other options.</td>
<td>The SBC for the coverage option in which he or she is currently enrolled (presumably, the version of the SBC for the coming year).</td>
<td>Hard copy, or electronically if enrollment is electronic; if paper enrollment, may supply SBC electronically in accordance with stricter DOL rules.</td>
<td>Where the enrollee’s current coverage option is being eliminated, we presume the plan may supply the new SBC for the option to which the enrollee’s coverage is being mapped. We presume the plan is to supply the new version of the SBC (i.e. for the coming year). If it is not available at open enrollment, the plan may supply the current year’s version, but supply the new version prior to the first day of the new plan year.</td>
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<td>NLT 30 days prior to new plan year, if re-enrollment is automatic and no opportunity to choose other option; may be later for insured plans where renewal is late (7 business days after renewal issued or committed to by insurer).</td>
<td>The SBC for the coverage option in which he or she is currently enrolled (presumably, the version of the SBC for the coming year).</td>
<td>Hard copy, or electronically if re-enrollment is electronic (presumably), otherwise in accordance with stricter DOL rules.</td>
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<td>Upon request, SBC should be sent within 7 business days.</td>
<td>The requested SBC.</td>
<td>Hard copy, or electronically if the individual makes the request electronically.</td>
<td>Typically, SBCs delivered to the employee are deemed delivered to dependents unless the plan knows a dependent does not reside with the employee.</td>
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<td>NLT 60 days prior to any mid-year material change to coverage, that changes information reflected in the SBC.</td>
<td>Either an updated SBC, or a summary of the change (but consistent with style and format of SBC).</td>
<td>Hard copy, or electronically in accordance with stricter DOL rules.</td>
<td>Plan may combine an SBC with other materials, such as the SPD or enrollment guide, if prominently displayed at the beginning of the document.</td>
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<td><strong>Special Enrollees</strong></td>
<td>Within 90 days after special enrollment.</td>
<td>The SBC for the coverage option in which he or she enrolled.</td>
<td>Hard copy, or electronically in accordance with stricter DOL rules.</td>
<td>DOL’s stricter rules for electronic disclosure require e’ee to have workstation access to network, or consent to e-delivery.</td>
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<td><strong>Individuals Eligible for Coverage but Not Yet Enrolled</strong></td>
<td>Upon or prior to eligibility to enroll.</td>
<td>The SBC for each coverage option for which he or she is eligible.</td>
<td>Hard copy, or make available electronically in accordance with relaxed rules (see Notes).</td>
<td>SBCs for individuals not yet enrolled may be provided electronically &quot;such as by email or an Internet posting&quot; as long as the SBCs are &quot;readily accessible.”</td>
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<td>At <strong>open enrollment</strong>: With or at time open enrollment materials are supplied.</td>
<td>The SBC for each coverage option for which he or she is eligible.</td>
<td>Hard copy, or make available electronically in accordance with relaxed rules (see Notes).</td>
<td>For SBCs posted on the Internet, this means the SBC must be in an accessible format (Word, PDF, HTML, etc.), and the plan must timely notify the individual via email or in writing (e.g., a postcard) about how to obtain the e-version, and that a paper version is available upon request.</td>
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<td>Auto-enrollment under health reform: unclear, where an eligible employee is defaulted into a coverage option.</td>
<td>Presumably, the SBC for the coverage option into which the employee is defaulted, under yet-to-be issued auto-enrollment rules.</td>
<td>Hard copy, or electronically in accordance with stricter DOL rules, presumably (see Notes on prior page).</td>
<td>Typically, SBCs delivered to the employee are deemed delivered to dependents unless the plan knows a dependent does not reside with the employee.</td>
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<td><strong>Upon request</strong>, SBC should be sent within 7 business days.</td>
<td>The requested SBC.</td>
<td>Hard copy, or electronically in accordance with relaxed rules (see Notes).</td>
<td>The plan may combine an SBC with other materials, such as the SPD or enrollment guide, if prominently displayed at the beginning of the document.</td>
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<td>Apparently, there’s no duty to affirmatively supply the SBC for the option in which the individual enrolls.</td>
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APPENDIX B—DOL REQUIREMENTS FOR ELECTRONIC DELIVERY OF STANDARD ERISA NOTICES
DOL REQUIREMENTS FOR ELECTRONIC DELIVERY OF STANDARD ERISA NOTICES

Lockton Summary of E-Disclosure Steps_030512.pdf
APPENDIX C—LIST OF COUNTIES
LIST OF COUNTIES (IF PLAN PARTICIPANTS RESIDE IN A LISTED COUNTY, THE SBC MUST COMPLY WITH OFFER OF TRANSLATION ASSISTANCE REQUIREMENT), AND MODEL NOTICE LANGUAGE

Here is model language federal authorities say should be displayed “prominently” in an SBC, where the participant resides in a county that according the most recent census contains residents at least 10 percent of whom are fluent only in the same non-English language. Federal authorities have offered this model language in four different languages. Following the model language is a list of relevant counties, and the relevant foreign language for each:

SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].

Updated Table of Counties.pdf
Our Mission
To be the worldwide value and service leader in insurance brokerage, employee benefits, and risk management

Our Goal
To be the best place to do business and to work

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