To whom must the SBCs be provided?

According to the final regulations, the SBC are provided to a "participant" and "beneficiary" as defined in ERISA §§ 3(7) and 3(8). These terms are defined to include not only those individuals who are currently enrolled in the plan (covered employees/former employees and their dependent) but anyone who is eligible to enroll. Consequently, a SBC must be provided to employees (including former employees) and their dependents that are enrolled OR eligible to enroll in the group health plan.

If the SBC is sent to an address in a county in which ten percent or more of the population is literate only in a non-English language then it must include a one-sentence statement in that non-English language about the availability of language assistance services. The final SBC regulations provide that a plan is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of the claims and appeals regulations are met. The claims and appeals regulations (applicable to non-grandfathered plans) outline three requirements that must be satisfied for notices sent to an address in a county in which ten percent or more of the population is literate only in a non-English language. In such cases, the plan is generally required to provide oral language services in the non-English language, provide notices upon request in the non-English language, and include in all English versions of the notices a statement in the non-English language clearly indicating how to access the language services provided by the plan.

Accordingly, plans must include, in the English versions of SBCs sent to an address in a county in which ten percent or more of the population is literate only in a non-English language, a statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the plan or issuer. In this circumstance, the plan or issuer should include this statement on the page of the SBC with the "Your Rights to Continue Coverage" and "Your Grievance and Appeals Rights" sections. Sample language for this statement is available on the model notice of adverse benefit determination at http://www.dol.gov/ebsa/IABDModelNotice2.doc. Current county-by-county data can be accessed at http://www.cciio.cms.gov/resources/factsheets/clas-data.html. This information is good for 2012 and will be updated annually.

Even in counties where no non-English language meets the ten percent threshold, a plan or issuer can voluntarily include such a statement in the SBC in any non-English language. Currently, there are four languages that meet the "10 percent or more of the population literate only in a non-English language" threshold. Those languages are Spanish (157 counties + Puerto Rico), Tagalog (currently applies to 2 counties in Alaska), Chinese (currently applies to San Francisco county), and Navajo (currently applies to 3 counties – Apache (AZ), McKinley (NM), and San Juan (UT)). Translated copies of the Uniform Glossary of Coverage and Medical Terms are available at http://cciio.cms.gov/resources/other/index.html#sbcug.

When must the SBC be provided?

Generally, plans must provide the required SBCs to participants or beneficiaries in the following circumstances:

- Upon "application" for coverage;
- Upon "renewal;"
- Following a request for a special enrollment (as defined by HIPAA);
- Upon request by a participant or beneficiary; and
- Following a material modification in the information contained in the SBC.

The timing and instances of SBC delivery will be discussed in more detail below.

The First SBCs

The SBC rules have two different effective dates, depending on the type of enrollment period. With respect to participants and beneficiaries enrolling during an annual enrollment period, the SBC rules are effective on the first day of the first annual enrollment period beginning on or after September 23, 2012.

For all other participants and beneficiaries enrolling during an enrollment period other than annual enrollment (e.g., newly eligible individuals and special enrollees), the SBC rules are first effective with any enrollment occurring on or after the plan year that begins on or after September 23, 2012.

The following are examples that illustrate the application of the SBC effective date:

- **Example #1:** ABC sponsors a health plan that has a calendar plan year. Each year it begins the annual enrollment period for the following plan year on October 1. ABC must comply with the SBC rules with respect to individuals enrolling in the annual enrollment period that begin October 1, 2012. Thereafter, the SBC rules will apply to all initial and special enrollments that occur on or after January 1, 2013.

- **Example #2:** XYZ sponsors a health plan that has a calendar plan year; however, unlike ABC Plan XYZ typically beings annual enrollment for the following year on September 1 of each year. For XYZ, the first annual enrollment period to which the SBC rule will apply is the annual enrollment period beginning September 1, 2013 (for the 2014 plan year). However, the SBC rules will apply to all initial and special enrollments that occur on or after January 1, 2013.

Enrollments Other than Annual and Special Enrollments Occurring after the Effective Date (of the rules on the Plan)

Plans must provide the SBCs to individuals who become eligible to enroll (except during a special enrollment period) with any written (or electronic) enrollment materials distributed by the plan as part of the enrollment process. If the plan does not provide written or electronic enrollment materials as part of the initial enrollment process, the plan must provide the SBC no later than the first day on which the individual is otherwise eligible to enroll. If any of the information required to be in the SBC that was provided during the enrollment process changes before the first day of coverage, then an updated SBC must be provided no later than the first day of coverage.

The following are examples that illustrate the application of this rule:

- **Example #3:** Bob is hired by ABC on October 1, 2013, and becomes eligible for coverage under ABC's group health plan on that date. ABC's plan administrator sends Bob written enrollment materials on October 5, 2013. ABC satisfies the SBC rules if ABC provides the SBCs (or a postcard with a link to the SBCs, as permitted by the SBC rules) with the written enrollment materials sent to Bob on October 5, 2013.

- **Example #4:** Same facts as Example #3, except that ABC does not send written enrollment materials. Instead, ABC typically instructs new employees on the enrollment process, which begins immediately, during the employee orientation. In that case, ABC would need to provide the requisite SBCs in accordance with the ABC rules on the date of the employee's orientation.

Special Enrollments Occurring after the Effective Date

Plans must provide the SBCs to special enrollees during a special enrollment period, as defined by HIPAA's portability rules, within 90 days of becoming covered under the plan (i.e., the date that a Summary Plan Description is otherwise required to be provided under ERISA). Unlike the other enrollment periods, a plan is not required to provide an SBC at the beginning of a special enrollment period.

Of note is that special enrollments under HIPAA's portability rules are not the only situations in which an individual may be able to enroll him/herself or a beneficiary in a plan during the plan year. For example, an employee's election for a group health plan benefit offered through a cafeteria plan may, to the extent permitted by a cafeteria plan, be changed mid-year to add a spouse whose coverage period under the spouse's employer's plan is different than the employee's plan, or where the spouse's employer significantly increased the cost of the spouse's coverage. These events that enable an individual to request mid-year

enrollment are not special enrollment events as defined by HIPAA. It is unclear as to which SBC rules apply to such mid-year enrollments – "applications", "special enrollments", or "upon request".

Annual Enrollment (Renewal)

If a written annual enrollment is required, the Plan must provide the SBCs with the written enrollment materials provided in connection with annual enrollment. If annual enrollment is automatic, the Plan must provide the SBCs no later than 30 days prior to the first day of the new plan year. Many plans utilize a "negative" or "passive" enrollment process where affirmative elections are made by participants only if the participant wishes to change his/her prior election. It is unclear whether or not this would be considered an automatic enrollment. The conservative plan sponsor may want to treat as a regular open enrollment or consult your legal counsel for guidance.

Upon Request by a Participant or Beneficiary

A plan must provide the SBCs to a participant or beneficiary upon request as soon as practicable, but no later than seven (7) business days following the receipt of the request.

Material Modifications

The SBC rules affect the timing for providing a summary of material changes (i.e., a summary of modification, or SMM) to participants. For covered plans, the revised process will include the process for distributing SMMs for covered plans. The timing will vary depending on whether the change is effective during the plan year or on the first day of the next plan year. Where a material modification (as defined in ERISA Section 102) is made to the terms of the plan that would impact the information in the most recently distributed SBC, and such change is effective during the plan year (i.e., prior to the first day of a subsequent plan year), a plan must provide notice of the material modification to "enrollees" at least 60 days *prior* to the effective date of the change. If it is a change effective as of the first day of the next plan year, a plan must provide an updated SBC in accordance with the SBC rules applicable to annual enrollment.

The preamble to the regulations indicates that "enrollee" (which is only used in this instance in the regulations) is interpreted by the agencies to mean "participant" and "beneficiary" ; therefore, a plan or insurer must arguably send an SBC notice of material modification for a benefit package to everyone who previously received an SBC for that benefit package.

The preamble to the final regulations states that the mid-year notice of material modifications can be in the form of a stand-alone notice that describes the material modification or an updated SBC. In either case, a plan must provide the notice of material modification in accordance with the SBC rules.

A copy of the regulations can be found at http://www.dol.gov/ebsa/healthreform/index.html

How must the SBC be delivered?

At a minimum, a plan must provide the SBCs in paper form. However, a plan may provide an SBC electronically according to the following rules:

For those who are covered under the plan:

An SBC may also be provided electronically by a plan or issuer to a participant or beneficiary *who is covered under a plan* in accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b-1. Those regulations include a safe harbor for disclosure through electronic media to participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties. Under the safe harbor, other individuals may also opt into electronic delivery.

The "opt in" safe harbor currently set forth in the DOL regulations imposes strict requirements on plan administrators. For example under the SPD electronic disclosure safe harbor, while SPDs may automatically be provided to employees who have routine access to the electronic medium as part of their job function, plans may generally provide the SPD electronically to employees who do not have routine access and non-employees (e.g., retirees, spouses, COBRA continuees) only if such individual provides affirmative electronic consent. Obtaining consent may pose administrative difficulties for plans or insurers.

For those who are eligible but not enrolled:

With respect to group health plan coverage, an SBC may be provided electronically by a plan to participants and beneficiaries, *who are eligible but not enrolled for coverage*, if:

- The format is readily accessible (such as in an html, MS Word, or pdf format);
- The SBC is provided in paper form free of charge upon request; and
- If the SBC is provided via an Internet posting (including on the HHS web portal), the plan timely advises the participants and beneficiaries that the SBC is available on the Internet and provides the Internet address. Plans may make this disclosure (sometimes referred to as the "e-card" or "postcard" requirement) by email.

The following is model language provided by the DOL for the "e-card" or "postcard" notification:

> **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).

In addition, as stated previously, unless the plan or issuer has knowledge of a separate address for a beneficiary, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form).

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call GPA at 1-800-827-7223. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 812-547-6427 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** person/**$2,000** family PPO & Non-PPO	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	**Yes.** Prescriptions & PPO preventive services do not apply towards the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Coinsurance Maximum: $2,000** person/ **$4,000** family Level I & Level II PPO & Non-PPO **Total Annual Maximum: $4,500** person/ **$9,000** family Level I & Level II PPO & Non-PPO (includes deductible & copayments)	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums; balance-billed charges; charges in excess of UCR (Usual, Customary & Reasonable); any noncompliance penalties; and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** Visit www.cigna.com or call 1-866-206-3224 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider	Non-PPO Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance; deductible applies	50% coinsurance; deductible applies	There is no charge for United Concierge Medicine consultations, PPO female office sterilization & all PPO FDA approved contraceptive methods. Chiropractic services are limited to 25 visits per calendar year. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Specialist visit	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Preventive care/screening/ immunization	No Charge	50% coinsurance; deductible applies	See your plan document for additional benefit information & limitations. Non-PPO charges are subject to Usual, Customary & Reasonable fees. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance; deductible applies	30% coinsurance; deductible applies	There is no charge for labs billed by Perry County Memorial Hospital. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Imaging (CT/PET scans, MRIs)	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Non-PPO charges are subject to Usual, Customary & Reasonable fees.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Copays: Retail $3/Mail Order $3		Covers a 30-90 day supply for Retail/90-day supply for Mail Order/30-day supply for Specialty. See your plan document for information about drugs that require prior authorization and drugs that are excluded.
	Preferred brand drugs	Copays: Retail 20% up to $25 maximum Mail Order $25		
	Non-preferred brand drugs	Copays: Retail 30% up to $35 maximum Mail Order $35		
	Specialty drugs	Copays: $3 Generic 20% up to $25 maximum Preferred Brand 30% up to $35 maximum Non-Preferred Brand		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance; deductible applies	50% coinsurance; deductible applies	UR notification required or 50% benefit reduction non-compliance penalty applies. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Physician/surgeon fees	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you need immediate medical attention	Emergency room care	20% coinsurance; deductible applies	20% coinsurance; deductible applies	UR notification required if admitted inpatient or 50% benefit reduction non-compliance penalty

[* For more information about limitations and exceptions, see the plan or policy document at www.gpatpa.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider	Non-PPO Provider	
				applies. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Emergency medical transportation	20% coinsurance; deductible applies	20% coinsurance; deductible applies	Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Urgent care	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Non-PPO charges are subject to Usual, Customary & Reasonable fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance; deductible applies	50% coinsurance; deductible applies	UR notification required or 50% benefit reduction non-compliance penalty applies. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Physician/surgeon fees	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	UR notification required for inpatient admissions or 50% benefit reduction non-compliance penalty applies. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Inpatient services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you are pregnant	Office visits	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Contact UR for coordination of prenatal care. UR notification required or 50% benefit reduction non-compliance penalty applies. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Childbirth/delivery professional services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Childbirth/delivery facility services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you need help recovering or have other special health needs	Home health care	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Services are limited per calendar year to 100 visits (max 4 hours per visits) for Home Health Care, 25 visits each for Physical/Occupational/Speech Therapy & 30 combined days for Skilled Nursing/ Rehabilitation Facilities. Treatment of developmental delays may not be covered. See your policy or plan document for additional information about **excluded services.** UR notification required for inpatient admissions, home health, outpatient hospice, DME & prosthetics or 50% benefit reduction non-compliance penalty applies. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Rehabilitation services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Habilitation services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Skilled nursing care	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Durable medical equipment	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Hospice services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If your child needs	Children's eye exam	No Charge	50% coinsurance;	Benefit applies to routine vision screenings up to

[* For more information about limitations and exceptions, see the plan or policy document at www.gpatpa.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider	Non-PPO Provider	
dental or eye care			deductible applies	age 19. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Children's glasses	Not Covered		Not Covered
	Children's dental check-up	Not Covered		Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- 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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic Care
- Hearing Aids (**only** for initial purchase if hearing loss is due to illness, accidental injury, congenital anomaly or surgical procedure)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 800-827-7223 or the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

[* For more information about limitations and exceptions, see the plan or policy document at www.gpatpa.com.]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$40
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,100**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$440
Coinsurance	$380
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,880**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,180**

The plan would be responsible for the other costs of these EXAMPLE covered services.