

The Summary of Benefits and Coverage (SBC)

Your guide to understanding this provision



The Basics

The Patient Protection and Affordable Care Act has established many new requirements and standards for insurers and group health plans (plan sponsors), including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health insurance industry to allow consumers to easily compare options and select health plans.

This brochure has been designed to answer some of your questions and help you understand the changes AmeriHealth will be making with respect to the SBC. An important date to keep in mind is September 23, 2012, which is when the new requirements take effect. All requirements related to the SBC are available at www.healthcare.gov.

We are committed to helping you understand these new requirements and are available to guide and assist you.

Important things you need to know about the SBC requirements

How does the SBC requirement affect my group's health plan?

A standard SBC and a Uniform Glossary of Terms, must be provided when offering group or individual health insurance whether fully-insured and/or self-funded.

Who is responsible for creating the SBC?

For fully-insured health plans, AmeriHealth and the plan sponsor are both responsible for meeting the SBC requirements to create and deliver SBCs to members. For self-insured health plans, it is the sole responsibility of the self-insured plan to meet the SBC requirements to create and distribute SBCs to members. To assist our customers in meeting these requirements, AmeriHealth will create and distribute SBCs for all of our fully-insured and self-funded customers. There are no fees or charges associated with this service.

How will the SBC be distributed?

SBCs will be available in either electronic form via amerihealthexpress.com or paper form.

When will the SBC be available?

The law requires the SBCs to be available on or after September 23, 2012. To assist our customers with upcoming open enrollments, we will begin accepting requests for SBCs on September 5, 2012.

AmeriHealth recommends that all customers work with their legal counsel and carefully review the SBC requirements. There are certain events that require the creation and distribution of a SBC as well as penalties for non-compliance. To help ensure your compliance with the SBC regulations it is important that you work with your independent broker or AmeriHealth account executive to finalize your benefit decisions early.

Timeline example of SBC requirements

	Group anniversary (Effective date)	Open enrollment date	SBC required for open enrollment in 2012	When is SBC required for special enrollment/newly eligible enrollees
Example 1	October 1, 2012	August 27, 2012	No	Beginning October 1, 2012
Example 2	December 1, 2012	September 26, 2012	Yes	Beginning December 1, 2012

How does the SBC affect existing AmeriHealth benefit materials?

The SBC replaces the current Benefits Summary that summarizes the medical benefits available to the member under the member's health plan. The SBC does not replace the member booklet and welcome kit. These documents, which provide detailed coverage information, will continue to be available to your members.

To help your members obtain more detailed information about their plan, AmeriHealth will continue to offer the existing medical benefits summary if requested. It will be renamed Benefits at a Glance so there is no confusion with the SBC. It is important to understand that the Benefits at a Glance documents do not meet the standard requirements for the SBC.

Generally, when there is a reference to SBC, both the Summary of Benefits and Uniform Glossary are being referenced.

Overview of the SBC document

The SBC is a four-page document that summarizes information about the plan sponsor's health plans in a consistent and straightforward design. Using standard design and uniform language it is intended to be a reference tool to help consumers compare plans and make informed coverage decisions. Keep in mind that the Health and Human Services, Labor, and Treasury Departments have set the requirements for the information that is offered on each page of the SBC.

Insurance Company 1: Plan Option 1		Coverage Period: 01/01/2013 – 12/31/2013		
Summary of Benefits and Coverage: What this Plan Covers & What it Costs		Coverage for: Individual + Spouse Plan Type: PPO		
 <ul style="list-style-type: none"> Co-payments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service. Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your co-insurance payment of 20% would be \$200. This may change if you haven't met your deductible. The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.) This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts. 				
Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 co-pay/visit	40% co-insurance	none
	Specialist visit	\$50 co-pay/visit	40% co-insurance	none
	Other practitioner office visit	20% co-insurance for chiropractor and acupuncture	40% co-insurance for chiropractor and acupuncture	none
	Preventive care/screening/immunization	No charge	40% co-insurance	
If you have a test	Diagnostic test (x-ray, blood work)	\$10 co-pay/test	40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	\$50 co-pay/test	40% co-insurance	none

Keep in mind that the SBC only replaces the new *Benefits at a Glance* (formerly benefits summary); not member booklets and welcome kits.

A closer look at what the SBC will include:

- A general overview of how the health plan works. For example, information on deductibles, cost sharing, and requirements for specialist visits.
- Limitations and exceptions such as precertification requirements, referral requirements, and visit limits are detailed.
- Ancillary product information such as out-of-pocket costs for certain prescription drug coverage, dental, or eye care.
- Excluded services are displayed according to health plan coverage.

The SBC also includes "coverage examples" to illustrate expected costs for certain procedures. The "examples" are very specific and show what the health plan would generally cover in two common medical situations — Having a Baby or Managing Type 2 diabetes. The examples are designed to help consumers understand and compare the costs of coverage.

Insurance Company 1: Plan Option 1		Coverage Period: 1/1/2011 – 12/31/2011																																																							
Coverage Examples		Coverage for: Individual + Spouse Plan Type: PPO																																																							
<h3>About these Coverage Examples:</h3> <p>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.</p>		<h3>Having a baby</h3> <p>(normal delivery)</p> <ul style="list-style-type: none"> ■ Amount owed to providers: \$7,540 ■ Plan pays \$5,490 ■ Patient pays \$2,050 <table border="1"> <caption>Sample care costs:</caption> <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>\$900</td></tr> <tr><td>Anesthesia</td><td>\$900</td></tr> <tr><td>Laboratory tests</td><td>\$500</td></tr> <tr><td>Prescriptions</td><td>\$200</td></tr> <tr><td>Radiology</td><td>\$200</td></tr> <tr><td>Vaccines, other preventive</td><td>\$40</td></tr> <tr><td>Total</td><td>\$7,540</td></tr> </table> <p>Patient pays:</p> <table border="1"> <tr><td>Deductibles</td><td>\$700</td></tr> <tr><td>Co-pays</td><td>\$30</td></tr> <tr><td>Co-insurance</td><td>\$1320</td></tr> <tr><td>Limits or exclusions</td><td>\$0</td></tr> <tr><td>Total</td><td>\$2,050</td></tr> </table>		Hospital charges (mother)	\$2,700	Routine obstetric care	\$2,100	Hospital charges (baby)	\$900	Anesthesia	\$900	Laboratory tests	\$500	Prescriptions	\$200	Radiology	\$200	Vaccines, other preventive	\$40	Total	\$7,540	Deductibles	\$700	Co-pays	\$30	Co-insurance	\$1320	Limits or exclusions	\$0	Total	\$2,050	<h3>Managing type 2 diabetes</h3> <p>(routine maintenance of a well-controlled condition)</p> <ul style="list-style-type: none"> ■ Amount owed to providers: \$4,100 ■ Plan pays \$2,480 ■ Patient pays \$ 1,620 <table border="1"> <caption>Sample care costs:</caption> <tr><td>Prescriptions</td><td>\$1,500</td></tr> <tr><td>Medical Equipment and Supplies</td><td>\$1,300</td></tr> <tr><td>Office Visits and Procedures</td><td>\$730</td></tr> <tr><td>Education</td><td>\$290</td></tr> <tr><td>Laboratory tests</td><td>\$140</td></tr> <tr><td>Vaccines, other preventive</td><td>\$140</td></tr> <tr><td>Total</td><td>\$4,100</td></tr> </table> <p>Patient pays:</p> <table border="1"> <tr><td>Deductibles</td><td>\$800</td></tr> <tr><td>Co-pays</td><td>\$500</td></tr> <tr><td>Co-insurance</td><td>\$240</td></tr> <tr><td>Limits or exclusions</td><td>\$80</td></tr> <tr><td>Total</td><td>\$1,620</td></tr> </table> <p>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].</p>		Prescriptions	\$1,500	Medical Equipment and Supplies	\$1,300	Office Visits and Procedures	\$730	Education	\$290	Laboratory tests	\$140	Vaccines, other preventive	\$140	Total	\$4,100	Deductibles	\$800	Co-pays	\$500	Co-insurance	\$240	Limits or exclusions	\$80	Total	\$1,620
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About the Uniform Glossary of Terms

The Uniform Glossary of Terms contains standard definitions of many frequently used health insurance and medical terms. Like the SBC, its intent is to assist consumers through the use of common terminology. The Uniform Glossary may not be modified by group health plans (plan sponsors) or insurers. The SBC must disclose the right of the individual to request a copy of the Uniform Glossary and insurers and group health plans (plan sponsors) must make the Uniform Glossary available upon request in either paper or electronic form within seven days.

How You and Your Insurer Share Costs - Example

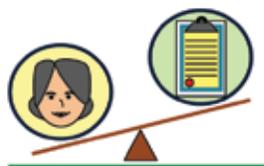
Jane's Plan Deductible: \$1,500

Co-insurance: 20%

Out-of-Pocket Limit: \$5,000

January 1st
Beginning of Coverage
Period

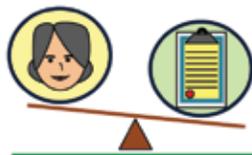
December 31st
End of Coverage Period



Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.
Office visit costs: \$125
Jane pays: \$125
Her plan pays: \$0

more costs



Jane reaches her \$1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.
Office visit costs: \$75
Jane pays: 20% of \$75 = \$15
Her plan pays: 80% of \$75 = \$60

more costs



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

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: \$200
Jane pays: \$0
Her plan pays: \$200

For more information about health care reform please visit the health care reform section of amerihealth.com. If you have questions about the SBC, please contact your independent broker or AmeriHealth account executive.



amerihealth.com