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Summary of Benefits and Coverage (SBC) requirements

Update for brokers and consultants who support Aetna medical plans — for all market segments — including individuals.

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Summary of Benefits and Coverage (SBC) law impacts everyone

At Aetna, we believe the Affordable Care Act (ACA) is an important milestone in addressing the challenges facing our health care system. We are guided by our values and the vision of a health care system that helps all Americans access affordable, quality health care.

We are committed to fostering compliance with the ACA and helping our customers achieve the same. This flyer will help you understand the SBC requirements and what we all must do to comply.

The ACA mandates a new plan document entitled Summary of Benefits and Coverage (SBC). The mandates are effective September 23, 2012, and include strict timeframes for the generation and distribution of the SBC — penalties apply for noncompliance. It is therefore important for everyone to understand what the SBC entails and how to comply with these new requirements.

The regulation applies to:	The regulation does not apply to:
• Self-funded and insured medical plans • Individual plans • Limited benefit plans • Student health insurance • Expatriate plans (U.S.-based benefits only) • Certain other plan types (e.g., HRAs, pharmacy and EAP if considered a group health plan)	• HSAs • Standalone dental and vision • FSAs (if excepted) • Certified retiree-only plans

Your actions help your customers stay compliant with the law

Everyone has a role to play. Where you agree to support us or our customers, you too must comply with the law. To comply, we must deliver SBCs to insured customers, as well as to members and potential members based on these "trigger" events:

- Before plan renewal
- With enrollment materials or during the enrollment period
- To newly eligible employees
- After a special enrollment
- Before making mid-year changes to medical plans
- Upon request

For insured plans, penalties for noncompliance apply to the insurer (or administrator) and customers. For self-funded plans, penalties apply to customers. Where you agree to support us or our customers, your actions impact our compliance with the law. That's why it's important for you to:

- Understand the new SBC requirements
- Provide required documents with required timelines when you agree to support your customers and Aetna
- Help guide your customers toward compliance
- Encourage customers to make timely plan/benefit decisions for new and renewing contracts. Plan information delivery deadlines are mandated.

If there are any plan changes after delivery, your customer will have to send a second mailing or face penalties.*

*See back cover for more about penalties.

SBC form information

Comparing plans is easy with the SBC

The purpose of the SBC is to give members* information about a health insurance plan's benefits in "plain language," so they can make appropriate purchasing, enrollment and coverage decisions. All customers and insurers must use the SBC document format prescribed by the final regulations.

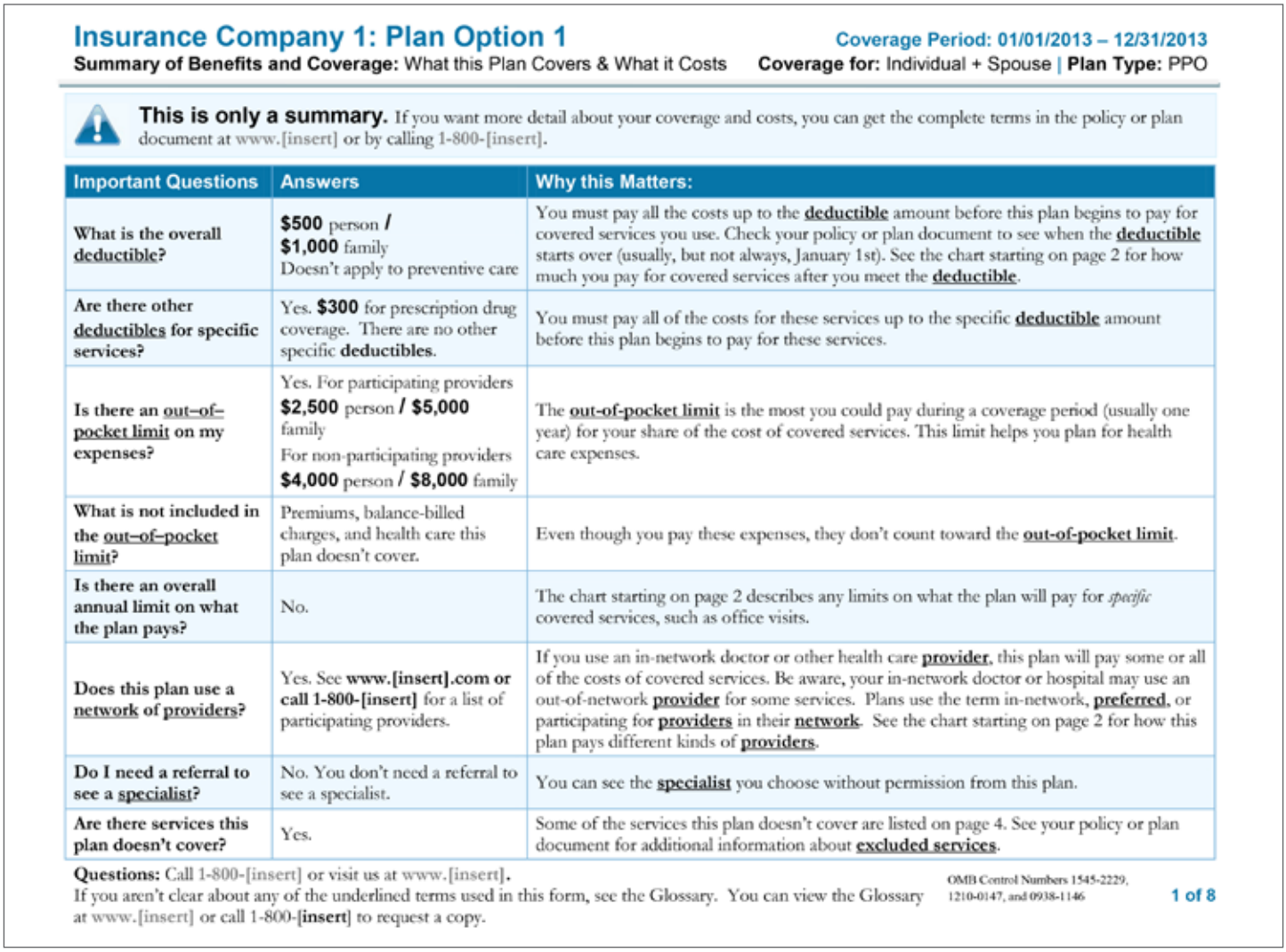
The required, four-page (double-sided) SBC document includes:

- Basic benefits and coverage, cost sharing requirements and exclusions and limitations of the plan
- Two coverage examples: one for having a baby and one for Type 2 Diabetes
- Information about how to access a "uniform" glossary that provides definitions of health coverage and medical terminology used in the SBC. The glossary must also be provided upon request. A link to the glossary will be included in the SBCs that Aetna provides to plan sponsors.

The law also requires that customers and insurers make the SBC available upon request, in non-English languages (currently the regulations require support for four threshold non-English languages including: Spanish, Mandarin, Tagalog and Navajo).

For more information visit:
http://cciio.cms.gov/resources/other/index.html#sbcug.

Sample SBC page



Insurance Company 1: Plan Option 1
Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage Period: 01/01/2013 – 12/31/2013
Coverage for: Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	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.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.[insert].com or call 1-800-[insert]** for a list of participating providers.	If you use an in-network doctor or other health care 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 term 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.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-**[insert]** to request a copy.

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

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*"Members" refers to potential and actual members.

Roles and responsibilities

To be compliant, we must meet the required SBC deadlines

Depending on the plan, group size, and funding arrangement, everyone has a role in delivering SBCs to members. The following three charts show the trigger* points by market segment and the roles of Aetna, customers and brokers.

1. Customers with more than 100 lives

General trigger timeframe requirements This is summary information of the triggers. Please refer to the actual requirements for details.	Roles for insured plans Brokers and consultants may agree to help customers meet the SBC requirements within the trigger timeframes.	Roles for self-funded plans Brokers and consultants may agree to help customers meet the SBC requirements within the trigger timeframes.
Open enrollment and renewals on or after September 23, 2012		
For active enrollment periods during which members actively sign up for a plan, the SBC must be provided with enrollment materials. For automatic enrollments in which members do not have to take any action to sign up for or renew a plan, the SBC must be provided no later than 30 calendar days before the effective date of the new policy.	Aetna will generate and provide SBC to customers. We rely on the customers to provide SBC to members. We will support requests for copies of SBCs received from active members enrolled in a plan that meets the SBC distribution criteria. **Avoid duplication: Help customers finalize benefits before SBC is generated** If information in the SBC changes between the date the enrollment/application materials were provided to members and the first day of coverage, then customers must provide a **new** SBC to the member by the first day of coverage.	Aetna will generate and provide SBC to customers. We rely on the customers to provide SBC to members. We provide two sets of SBCs at no cost for each customer per year for each unique active Aetna medical plan offered: • To support open enrollment activities • To support material plan changes during the plan year (if needed)
New eligible members (such as new hires)		
SBC must be provided: • With enrollment/application materials • If enrollment materials are not distributed, no later than 1st day of enrollment period	Aetna will generate and provide SBC to customer. We rely on the customer to provide SBC to members.	Customer provides SBC to member.
Special Enrollment Period (i.e., those subject to HIPAA Special Enrollment)		
90 calendar days from enrollment	Aetna will generate and provide SBC to customer. We rely on the customer to provide SBC to members.	Customer provides SBC to member.
Upon request for summary information about a health insurance product or SBC		
Within 7 business days of receipt of request	Aetna will provide SBCs when requests come directly to us. If member or customer requests from you, provide SBC in required timeframe.	• If member or customer requests from you, provide SBC in required timeframe. • You may also need to support member requests per any agreements you have with your customers.
Material Modifications, as defined by ERISA		
No later than 60 calendar days before the effective date of the coverage change(s), send a Notice of Material Modification or revised SBC.	Aetna will provide SBC to customer, who will provide to member.	Aetna would need to generate SBC if requested. Customer provides SBC to member.

*There are other requirements related to the SBC, including language assistance and delivery (e.g., electronic vs. paper) requirements. For information about these requirements or the full set of SBC regulations visit: **www.dol.gov/ebsa/healthreform/**.

2. Customers with fewer than 100 insured lives*

Trigger timeframe requirement This is summary information of the triggers. Please refer to the actual requirements for details.	Aetna's role	Broker roles and responsibilities Brokers and consultants are responsible for helping Aetna meet certain SBC requirements within the trigger timeframes.
Upon renewal on or after September 23, 2012		
No later than 30 calendar days before 1st day of the new policy effective date NOTE: If the policy is not finalized, the date is as soon as practical, specifically, within 7 business days after the start of the new policy, or within 7 business days after the receipt of written confirmation of intent to renew — whichever is earlier.	We will automatically send SBCs to renewing customers for renewal dates 10/1/2012 and later. • For plans renewing 10/1/2012 through 2/15/2013, we'll send SBCs in a separate mailing from the renewal package. • For renewals effective on or after 3/1/2013, we will combine the SBC with the rate renewal package in one mailing. • At the time SBCs are sent to the customer, we also e-mail SBCs to the broker.	No action is needed.
Upon application (New business)		
Within 7 business days of receipt of application	We will publish SBC documents on Producer World®. • We will make SBCs available by 9/23/2012 for groups that are applying for new business effective 10/1/2012 and later. • Brokers are responsible for distributing the SBC and supplemental documents to new groups.	Broker will retrieve the SBCs and application materials from Producer World and distribute SBC to customer in accordance with established timeframes.
Upon enrollment beginning on or after September 23, 2012		
With enrollment materials or no later than the first day of the open enrollment period, defined as the time period in which members make their annual elections	We will generate SBCs and post to Producer World.	• Broker provides SBCs to the customer for new business. • Customers provide SBCs (paper or electronic) to members before members make enrollment election.
Upon request for summary information about a health insurance product or SBC		
Within 7 business days from receipt of date of request (applies to both customer and member requests)	• For customer requests, we will publish SBCs on Producer World beginning 9/23/12. • Members can call Member Services for a copy of their SBC only after their next open enrollment.	When customer requests detailed benefit information, you can retrieve SBCs from Producer World.
Material modifications, as defined by ERISA		
No later than 60 calendar days before the effective date of the coverage change(s), send a Notice of Material Modification or revised SBC	We will provide the notification to plan sponsors in required timeframe. We will post the updated SBC to Aetna Navigator®.	If needed, you can access the updated SBC on Producer World.
Newly eligible		
With enrollment materials or, if no enrollment materials are distributed, no later than the first day the individual is eligible to enroll	No action by Aetna.	Customers are responsible for providing SBCs to newly eligibles.
Special enrollees subject to HIPAA special enrollment requirements		
No later than 90 days from enrollment	No action by Aetna.	Customers are responsible for providing SBC to special enrollees.

*Some customers with fewer than 100 lives are not currently treated within this category. But, they will be moved into this category over the next few months, to be completed by the end of 2012. This impacts only a few customers. Please check with your Aetna representative if you have questions about any specific customer.

3. Individual plans

The following represents the events that would result in the distribution of an SBC for Individual plans and as those events relate to brokers. It does not reflect all SBC requirements.

Trigger timeframe	Aetna's role	Broker roles and responsibilities
Upon Renewal on or after 9/23/2012 (when calendar-year deductible and benefits reset)		
No later than 30 calendar days before 1st day of the new policy effective date	We will automatically send the SBC to the member.	No action is needed.
Upon Application		
Within 7 business days of receipt of the application	If we receive the completed application, we will provide the SBC to the applicant.	If you receive the completed application, you will provide the SBC to the applicant.
Upon Request for summary information about a health insurance product or SBC		
Within 7 business days of receipt of request	• Member can request SBC from broker or Member Services at any time. • If Member Services receives a request for plan information, we will send the SBC to the member. • If an individual asks for plan information presale, we will include the SBC in the enrollment package.	• If member asks for plan information, send the SBC with other materials. • Call your broker liaison team for translated SBCs. • Send SBC (English or translated) to members upon request.

SBC example scenarios for different open enrollment and plan effective dates

	Plan effective date	Open enrollment start dates	Is an SBC required for open enrollment in 2012?	On what date are SBCs required for newly eligible and special enrollees?
Scenario 1	10/1/2012	8/27/2012	No	Starting 10/1/2012
Scenario 2	1/1/2013	10/15/2012	Yes	Starting 1/1/2013

Scenario 1: Insured customers with 100+ lives

- Aetna will provide applicable SBCs to customers for plan(s) effective October 1, 2012.
- SBCs are not required for inclusion with enrollment materials.
- Beginning October 1, 2012, customers must provide SBC to members who enroll outside of open enrollment period (newly eligibles and special enrollees).

Scenario 2: Insured customers with 100+ lives

- Aetna will provide applicable SBCs to customers for plan(s) effective January 1, 2013.
- For the enrollment period commencing on October 15, 2012, customers must provide SBCs to members either (1) with application/enrollment materials if written application is required, or (2) by December 1, 2012 (30 days before 1st day of new policy year). In addition, since it is an insured plan, if the SBC has not been finalized, there is an exception allowing it to be provided by January 10, 2013 (7 business days after issuance of policy or 7 business days of receipt of written confirmation, whichever is earlier).
- Starting January 1, 2013, customers must provide SBCs to those who enroll outside of open enrollment period (newly eligibles and special enrollees) for plans effective January 1, 2013 and beyond.

Penalties for noncompliance

We (customers and Aetna) face significant financial risk and serious penalties for not complying with the SBC regulations.

Under the SBC requirements, willful failure to comply could result in up to a $1,000 fine per plan participant or beneficiary for each failure. There are also separate penalties that may apply that are not specific to the SBC regulation but can be imposed for failure to comply with certain federal requirements.

"Good Faith" effort clause

- In an FAQ issued on March 19, 2012, the Department of Health and Human Services (HHS) announced a non-enforcement period for the first year of applicability. During this time, penalties will not be imposed on plans and issuers that are working diligently and in "good faith" to provide the required SBC content in an appearance that is consistent with the final regulations.
- In an FAQ issued on May 11, 2012, the Departments extended its non-enforcement policy for the first year of applicability in response to a question regarding the delivery of an SBC or uniform glossary. Specifically, this FAQ indicated that penalties will not be imposed for failure to provide the SBC or the uniform glossary if "plans and issuers are working diligently and in good faith to comply."

Your actions impact others

When you support your customers and us in the generation and delivery of the SBCs, you must meet those same strict requirements and deadlines summarized above and on the government website. Your prompt actions to the SBC trigger and distribution timeframes will help us and your customers to comply with the regulations and avoid penalties.

Since there are potential penalties involved, we must work together to ensure everyone is compliant. It's important for us to be sure you understand the requirements. Therefore, we have added a new section in the standard Broker Agreement about support obligations you will need to meet. If you have questions, please contact your account representative or broker liaison.

For more information on health care reform, visit **www.aetna.com/health-reform-connection**

The information provided is a high level overview related to the Summary of Benefits and Coverage requirement pursuant to the Affordable Care Act, and should not be considered legal or compliance advice. This document does not represent a comprehensive view of the requirements. Information is subject to change. For more information on the regulation and guidance, go to **www.dol.gov/ebsa/healthreform/**.

This material is for general health information only and does not constitute legal advice. This material information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

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