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Important information about Summary of Benefits and Coverage (SBC) regulatory requirements

For Aetna insured plan sponsors with fewer than 100 lives

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 plan sponsor customers comply with the regulations. We want to help you understand what you need to know about the Summary of Benefits and Coverage (SBC) requirements and what you must do to comply.

Why the SBC requirements affect all plan sponsors

As a plan sponsor of an insured plan it is critical for you to understand what the SBC entails and how to comply with the new rule, **effective September 23, 2012**. You share with us a joint responsibility to comply with the requirements.

Beginning on September 23, 2012 – but not before – we will produce the SBC for you. Then it *is your responsibility to* ***distribute*** *SBC materials (electronic or printed) to your employees:*

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

You must meet these required delivery "triggers" to comply with the new SBC requirements. There are potential penalties if you don't comply. See back cover for more information.

What is the SBC?

SBC is a new plan document required by the ACA legislation. The purpose of an SBC is to give people straightforward information about a health insurance plan's benefits, to help consumers more easily compare plans and make appropriate enrollment and coverage decisions. An SBC is a four-page, double-sided document that uses plain language and a consistent format to summarize information about your available health plans.

The four-page document includes:

- A description of the benefits and coverage under a plan including cost-sharing requirements and any information about exceptions, reductions or limitations
- Examples of cost sharing under the health plan for coverage of two common scenarios: having a baby and managing Type 2 diabetes

In addition, an SBC must reference a glossary that provides definitions of health coverage and medical terminology used in the SBC. The glossary must be provided upon request. Note: We will include a link to the glossary on the SBCs that we provide to you.

Additional information on SBC requirements

An SBC must:

- Be provided in a culturally and linguistically appropriate manner
- Be made available, upon request, in non-English languages (currently there are four threshold non-English languages including: Spanish, Mandarin, Tagalog and Navajo)
- Follow electronic delivery requirements

Your responsibilities and timeframes for insured plans

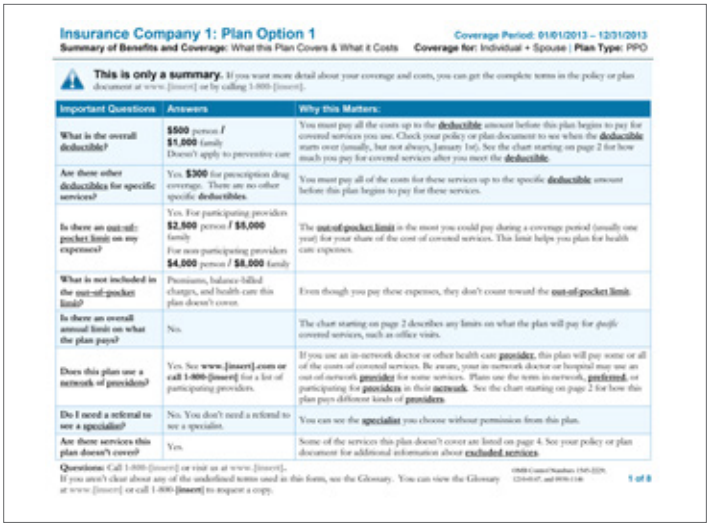
You must provide your employees with compliant SBCs during specific timeframes – called "triggers" – **on or after September 23, 2012.** The following chart illustrates the common triggers* and related details.

Customers with less than 100 lives

The requirement	General trigger timeframe requirements Note: This is summary information of the triggers. Please refer to the actual requirements for additional details.	What you must do
Open enrollments and renewals after September 23, 2012	• For enrollments in which employees actively sign up for a plan, the SBC must be provided with enrollment materials. • For automatic enrollments in which employees do not have to take any action to sign up for a plan, the SBC must be provided no later than 30 calendar days before the first day of the new policy effective date.	Provide SBC (generated by Aetna) to plan participant or beneficiary (as applicable). *Note: If information on the SBC changes between the date the enrollment/application materials were provided to employees and the first day of coverage, you must provide a new SBC to employees by the first day of coverage. It is important to finalize benefit information before the effective date of the plan so that employees can be provided the correct document before the first day of coverage.
Newly eligibles (e.g. new hires)	SBC must be provided: • With enrollment/application materials • Or, if enrollment materials are not distributed, no later than 1st day of enrollment period	Provide Aetna SBC to plan participants or beneficiaries (as applicable).
Special Enrollment Period (i.e., those subject to HIPAA Special Enrollment)	90 calendar days from enrollment	Provide Aetna SBC to plan participants or beneficiaries (as applicable).
Upon request of SBC or summary information about health insurance coverage	Within 7 business days of receipt of request	Provide SBC to plan participants or beneficiaries (as applicable).
Material Modifications, as defined by ERISA	If coverage information changes that would affect the content of the SBC, after 1st day of coverage, a Notice of Material Modification (can be in form of revised SBC) must be sent no later than 60 calendar days before the effective date of the coverage change(s)	Provide to plan participant or beneficiary (as applicable).

*There are other requirements related to the SBC, including language assistance, and delivery requirements. To access the regulations and regulatory guidance related to SBC, visit: **www.dol.gov/ebsa/healthreform/**

Sample SBC pages



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

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 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.
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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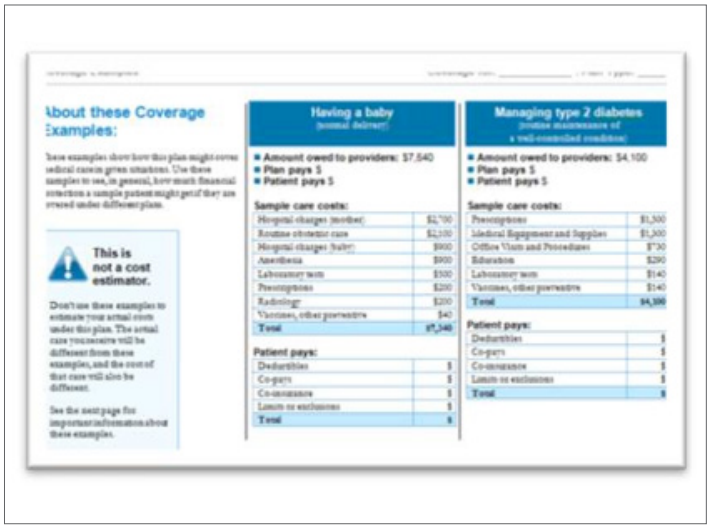

About these Coverage Examples:

These examples show how this plan might cover medical events 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.

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 $
- Patient pays $

Sample care costs:

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

Patient pays:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	$

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

- Amount owed to providers: $4,100
- Plan pays $
- Patient pays $

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,500
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	$4,100

Patient pays:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	$

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	12/1/2012	10/15/2012	Yes	Starting 12/1/2012

Scenario 1

- We will provide applicable SBCs to you for plan(s) effective 10/1/2012.
- SBCs are not required for inclusion with Open Enrollment materials.
- Starting 10/1/2012, you must provide SBC to employees who enroll outside of an Open Enrollment period (newly eligibles and special enrollees).

Scenario 2

- We will provide applicable SBCs to you for plan(s) effective 12/1/2012.
- For the enrollment period commencing on 10/15/2012, you must provide SBCs to participants/beneficiaries either (1) with application/enrollment materials if written application is required, or (2) by 11/1/2012 (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 you to provide it by 12/11/2012 (7 business days after issuance of policy or 7 business days of receipt of written confirmation, whichever is earlier).
- Starting with 12/1/2012, you must provide SBCs to those who enroll outside of open enrollment period (newly eligible and special enrollees) for the plan that is effective 12/1/2012.

We will help you fulfill the regulatory requirement

By law, we are required to generate SBCs for our insured plans, yet we will need to work closely with you to ensure accuracy.

It's important for you to understand the role you play. We recommend that you work with your legal counsel and carefully review SBC requirements, including the detailed information about the events that trigger the need for an SBC to fully understand them, and the potential penalties for noncompliance.

Joint accountability for distribution of SBCs

We share with you joint accountability for distributing the SBC to plan participants and beneficiaries within the required timeframes outlined above for each regulatory trigger.

- By law, we are required to give you SBCs for distribution to your workforce, yet we will need to work closely with you and/or your broker to ensure compliance.
- While we will support you by producing the SBC documents, we are relying on you to distribute the SBC to plan participants and beneficiaries. We will support requests for copies of SBCs received from active members enrolled in a plan that meets the SBC distribution criteria.
- Please note that registered Aetna Navigator® users will be able to view their SBC on the secure member website after the effective date of the plan.

Penalties for noncompliance

We want to make sure that you are aware of the potential penalties of not complying with the SBC regulations. As noted above, we are relying on you to distribute the SBC to plan participants and beneficiaries.

The law includes a "Good Faith" effort provision:

- In an FAQ issued on March 19, 2012, the U.S. Departments of Health and Human Services, Labor, and Treasury ("the Departments") announced a non-enforcement period for the first year of applicability. During this time period, 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 their 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."

Potential penalties

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.

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