



Small Group Employer's Guide to

The Summary of Benefits and Coverage (SBC)

Last Revised: June, 2016

If you have questions at any time, please contact your Sales Account Executive.

Click on the tabs below to learn more about the process for completing your SBC.

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Overview

The Summary of Benefits and Coverage (SBC) establishes standards that group health plan sponsors and insurers must use when offering group or individual health insurance. It was created by the departments of Health and Human Services, Labor and the Treasury (the departments). The SBC’s purpose is to accurately describe the benefits and coverage under the group plan.

Why the SBC requirement was created

Among other things, the standards were created to ensure that benefits and coverage information is presented in a clear and uniform format that helps plans and individuals better understand their health coverage and compare coverage options across different types of plans and insurance products.

The SBC was developed under section 2715 of the Public Health Service Act (PHS Act) as added by the Affordable Care Act (ACA).

What the SBC document includes

The departments consulted with the National Association of Insurance Commissioners (NAIC) to develop standards for providing SBCs.

This communication is not intended, nor should it be construed, as legal or tax advice. Please contact a competent legal or tax professional for legal advice, tax treatment and restrictions. Federal and state laws and regulations are subject to change.

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Make sure you comply



Willful failure to deliver your SBC to members within the required time frame may result in a fine of **\$1,000 per each covered individual.**



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The SBC must include:

- A description of the coverage (including the cost-sharing for each category of benefits identified by the departments)
- The exceptions, reductions or limitations on coverage
- The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations
- The renewability and continuation-of-coverage provisions
- Appeals/Grievance Rights
- Coverage examples, including common benefits scenarios for having a baby (normal delivery) or managing Type 2 diabetes (routine maintenance, well-controlled)
- A statement that the SBC is only a summary and that the plan document, policy or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage
- A contact number to call with questions and an Internet address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained
- An Internet address (or other contact information) for obtaining a list of the network providers, an Internet address where an individual may find more information about the prescription drug coverage under the plan or coverage, and an Internet address where an individual may review the Glossary of Health Coverage and Medical Terms (“Uniform Glossary”), and a disclosure that paper copies of the Uniform Glossary are available
- A uniform format, four double-sided pages in length and 12-point type
- A statement on whether the plan meets minimum essential coverage (MEC) and meets minimum value (MV: 60 percent of costs of benefits for a population). For UnitedHealthcare created SBCs, we will support group health plans with determining whether the plan or coverage meets the MV requirements for the UnitedHealthcare services that we provide.

[2017 SBC Template](#)
 (Final template for use on or after 4/1/17)

[2013 SBC Template](#)

[2012 SBC Template](#)

Click on the links to see the Department of Health and Human Services (HHS) sample completed SBC templates.



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The SBC provision went into effect under the ACA Sept. 23, 2012.

Enrollment during open enrollment period

The requirements to provide an SBC, notice of material modification and Uniform Glossary apply for disclosures to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period beginning on the first day of the first open enrollment period that began on or after Sept. 23, 2012.

Enrollment other than open enrollment

For SBC distributions to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (for example, special enrollees and new hires), the requirements apply beginning the first day of the first plan year that began on or after Sept. 23, 2012.

Other SBC distributions

For SBC distributions to group health plans by an insurer, these requirements are applicable and began on Sept. 23, 2012.

Click on the buttons below to find out more

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What's new

Overview of the SBC and Uniform Glossary Final Rule (June 2015)

The Final Rule incorporated previously issued guidance and adopted new standards. Among the changes:

- If the issuer provides the SBC upon request before application for coverage, the requirement to provide the SBC upon application is satisfied. However, this is only true if there is no change to the information required to be in the SBC.
- If the plan sponsor is negotiating coverage terms at the time of initial enrollment, an updated SBC reflecting the final coverage terms must be provided to the plan or its sponsor on the first day of coverage, or upon request.
- The departments retained three existing special anti-duplication provisions from the 2012 final regulations. The two provisions below were also added to ensure participants and beneficiaries receive information while preventing unnecessary duplication.
 1. If an entity required to provide an SBC has entered into a binding contract with another party to provide the SBC, the requirement to provide the SBC is met—if specified conditions, including monitoring performance, are satisfied. A similar anti-duplication rule was added that applies to student health insurance coverage.
 2. For a group health plan that uses two or more insurance products provided by separate issuers, the group health plan administrator is responsible for providing complete SBCs with respect to the plan. The group health plan administrator may contract with one of its issuers (or other service providers) to perform that function. Absent a contract to perform the function, an issuer has no obligation to provide coverage information for benefits that it does not insure. Additionally, the enforcement safe harbor permits a group health plan administrator to combine the information into a single SBC or provide multiple partial SBCs. Together, these partial SBCs should provide all the relevant information to meet the SBC content requirements.

- The departments also codified additional enforcement safe harbors from previously issued FAQs, including:
 1. The safe harbor relating to the electronic delivery of SBCs for members who enroll for coverage through an electronic enrollment system.
 2. Relief exempting Medicare Advantage benefits from the SBC requirements.
 3. Enforcement relief to insurance products that are no longer being offered for purchase (“closed blocks of business”).
- Until the new template and associated documents are finalized and applicable, the departments will not take enforcement action against a plan or issuer that provides an SBC with a cover letter or similar disclosure with the required minimum essential coverage and minimum value statements.
- Specific to individual market insurance coverage, if an issuer automatically re-enrolls an individual and any dependents into a different plan or product, the issuer will be required to provide an SBC for the enrolled coverage. The timing requirements that apply are consistent with when the policy is renewed or reissued.
- Qualified health plan issuers must disclose on the SBC for qualified health plans sold through an individual Marketplace whether abortion services are covered or excluded, and whether coverage is limited to excepted abortion services.
- A copy of the actual individual coverage policy or group Certificate of Coverage (COC) must be available online. This provision is applicable to issuers and not self-insured plans. For the group market only, an issuer is permitted to satisfy this requirement with respect to plan sponsors that are shopping for coverage by posting a sample COC for each applicable product. After the actual COC is executed, it must be easily available online to plan sponsors, participants and beneficiaries.



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What's new continued

- The SBC cannot exceed four double-sided pages. The departments will address specific issues related to completing the four-page template, as well as the problems plans and issuers may encounter meeting these requirements with the finalization of the new template and associated documents, separate from this Final Rule.

Applicability Dates with Respect to Disclosures to Participants and Beneficiaries

- The first day of the first open enrollment period that begins on or after September 1, 2015, for those who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees).
- The first day of the first plan year that begins on or after September 1, 2015, for those who enroll in group health coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees).
- In the individual market, the requirements apply to health insurance issuers with respect to SBCs issued for coverage that begins on or after January 1, 2016.

Applicability Dates with Respect to the New Template and Associated Documents

The Centers for Medicare and Medicaid (CMS), along with the Department of Labor (DOL), issued final updated templates for the SBC and uniform glossary. All group and individual health insurance plans and policies are required to provide an accurate SBC to applicants, enrollees, policyholders and certificate holders. These updated templates are required for:

- * Plans and policies with an open enrollment period beginning on the first day of the first open enrollment period that begins on or after April 1, 2017, for coverage effective on or after that date; or
- * Plans and policies with no open enrollment period beginning on the first day of the first plan or policy year that begins on or after April 1, 2017.



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For insured health plans, UnitedHealthcare and the Group Health Plan are jointly responsible for meeting the SBC requirements for creation and delivery of the SBCs to members. If you utilize external vendors for certain benefits, there could be additional tasks. UnitedHealthcare offers two ways to help you:

Partial SBC Creation (excluding external vendors)

If UnitedHealthcare provides your medical insurance coverage but you use external vendors for other benefit services, we will create the SBC, including calculating coverage examples, for the services that you insure through UnitedHealthcare. You will be responsible for completing any information from outside vendors and completing the calculation of the coverage examples within the SBC document.

Full SBC Creation (including external vendors)

If UnitedHealthcare provides your medical insurance coverage, but you use external vendors for other benefit services, we will create the SBC, including calculating coverage examples, for the services that you insure through UnitedHealthcare. Upon request (at no additional cost), we can incorporate the completed external vendor benefit information and calculate coverage examples, into a single, completed, and fully synergized SBC.* UnitedHealthcare can only make requested benefit change updates to the SBC going forward for the services that we provide you, unless the external vendor benefit information and recalculated coverage examples are provided by you.

Plans excluded from the SBC requirements include:

- Retiree-only
- Stand-alone dental or vision

*Customer is responsible for ensuring the accuracy of the information provided in the SBC Carve-Out Forms (Rx and Mental/Behavioral Health Substance Use Disorder). UnitedHealthcare shall not be responsible for any inaccuracies in the content of a completed SBC Carve-Out Form or the SBC that is generated using inaccurate information. UnitedHealthcare reserves the right to change the format or information requested on the SBC Carve-Out Forms at any time, with or without advance notice.



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2012 SBC template

2013 SBC template

2017 SBC template

Final template for use on or after 4/1/17

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
<p>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.[insuree] or by calling 1-800-[insuree].</p>		
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.[insuree].com or call 1-800-[insuree] 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 .
<p>Questions: Call 1-800-[insuree] or visit us at www.[insuree]. 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.[insuree] or call 1-800-[insuree] to request a copy.</p>		

Insurance Company 1: Plan Option 1		Coverage Period: 01/01/2014 – 12/31/2014
Summary of Benefits and Coverage: What This Plan Covers & What It Costs		Coverage for: Individual + Spouse Plan Type: PPO
<p>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.[insuree] or by calling 1-800-[insuree].</p>		
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.[insuree].com or call 1-800-[insuree] 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 .
<p>Questions: Call 1-800-[insuree] or visit us at www.[insuree]. 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.[insuree] or call 1-800-[insuree] to request a copy.</p>		

Summary of Benefits and Coverage: What This Plan Covers & What You Pay for Covered Services		Coverage Period: 01/01/2016 – 12/31/2016
Insurance Company 1: Plan Option 1		Coverage for: Family Plan Type: PPO
<p>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, (read certain information). For general definitions of common terms such as allowed amount, balance billing, coinsurance, co-payment, deductible, provider, or other additional terms see the Glossary. You can view the Glossary at www.[insuree].com or call 1-800-[insuree] to request a copy.</p>		
Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,000 individual or \$1,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before the plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible and the total amount of deductible expense paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your 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, the plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at http://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	Yes. \$300 for prescription drug coverage and \$300 for occupational therapy services.	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.
What is the out-of-pocket limit for the year?	For network providers \$2,500 individual / \$5,000 family, for out-of-network providers \$4,000 individual / \$8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care the 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. See www.[insuree].com or call 1-800-[insuree] for a list of network 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 need a referral from a provider for the difference between the provider's charge and what your plan pays (balance billing). So, always, your network provider might use an out-of-network provider for some services (such as lab tests). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .
<p>0949 Contract Numbers: 0345-0008, 1200-0047, and 0958-1146 Released on 04/01/16, 2016</p>		

Click on the thumbnails to see the Department of Health and Human Services (HHS) sample completed SBC templates.



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Deadlines

Timing is everything when it comes to properly completing your SBC.*

Group health plan SBC

A health insurance issuer that offers group health insurance must provide an SBC to the plan or plan sponsor:

- Within seven business days after receipt of an application for health coverage;
- By the first day of coverage, if there are any changes to the initial SBC;
- If written application for renewal is required, no later than the date the written application materials are distributed;
- If written application is not required for renewal, the later of 30 days before the beginning of the new plan or policy year or within seven business days of receiving the group’s intent to renew; and
- Within seven business days after receipt of a request from the plan or plan sponsor.

Member/employee SBC

The plan administrator or health insurance issuer (for insured plans) must provide an SBC to a member:

- As part of the written application or enrollment materials (i.e., new hire enrollment packet). If the plan does not distribute written enrollment materials, the SBC must be distributed no later than the first date on which the employee is eligible to enroll for coverage;

- By the first day of coverage, if there are any changes to the initial SBC;
- Within 90 days from enrollment for any special enrollee. A special enrollee is generally an employee who enrolls midyear upon the occurrence of a special enrollment event, such as marriage, birth of a child, or loss of other coverage;
- For renewal, if the member must actively elect to maintain coverage, or has the opportunity to change coverage options during an annual open enrollment period, an SBC must be distributed as part of the open enrollment materials;
- If written application is not required for renewal, the later of 30 days before the beginning of the new plan or policy year or within seven business days of receiving the group’s intent to renew; and
- Within seven business days after receipt of request by the member.

Here is a breakdown of the three main times when changes may be made to your SBC.



* The examples provided do not illustrate time frames requiring additional information needed for plans with external vendors. If an external vendor is being utilized, please include additional time to provide a consolidated and synergized SBC.



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At renewal

The timelines associated with changes at renewal are dependent upon whether the SBC update involves open enrollment or any actual benefit changes:

- **Benefit change with open enrollment**

UnitedHealthcare will provide the completed SBC electronically to you before open enrollment materials are distributed as long as we receive notification of benefit changes at least seven business days before we are required to deliver the SBC to you.

- **Benefit change with no open enrollment**

UnitedHealthcare will provide the completed SBC electronically to you before the effective date of the plan as long as we receive notification of benefit changes at least seven business days before we are required to deliver the SBC to you.

- **No benefit change**

If there are no changes to your current SBC, the existing SBC will be updated to reflect the new coverage period and provided to you electronically within the time frames stated above.

Sample timeline with open enrollment

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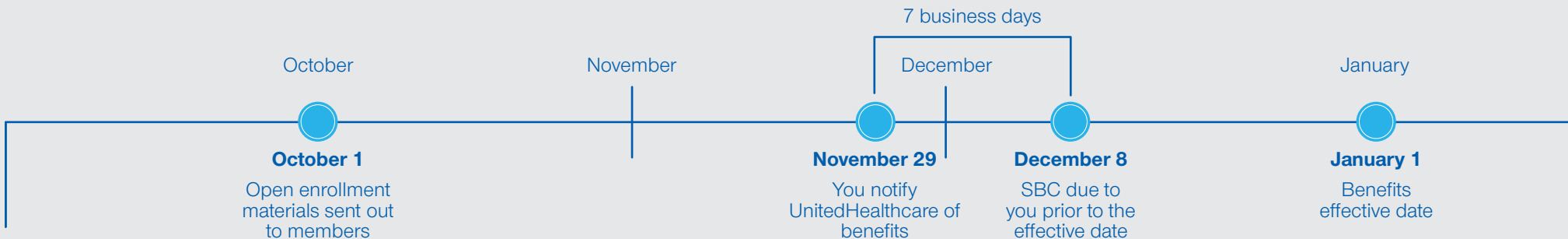
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Prior to renewal (changes between open enrollment and renewal)

If you have changes prior to renewal, but after distribution of the first SBC, UnitedHealthcare will provide you the completed SBC electronically by the first day of coverage as long as we receive notification of benefit changes at least seven business days before the first day of coverage.

Sample timeline

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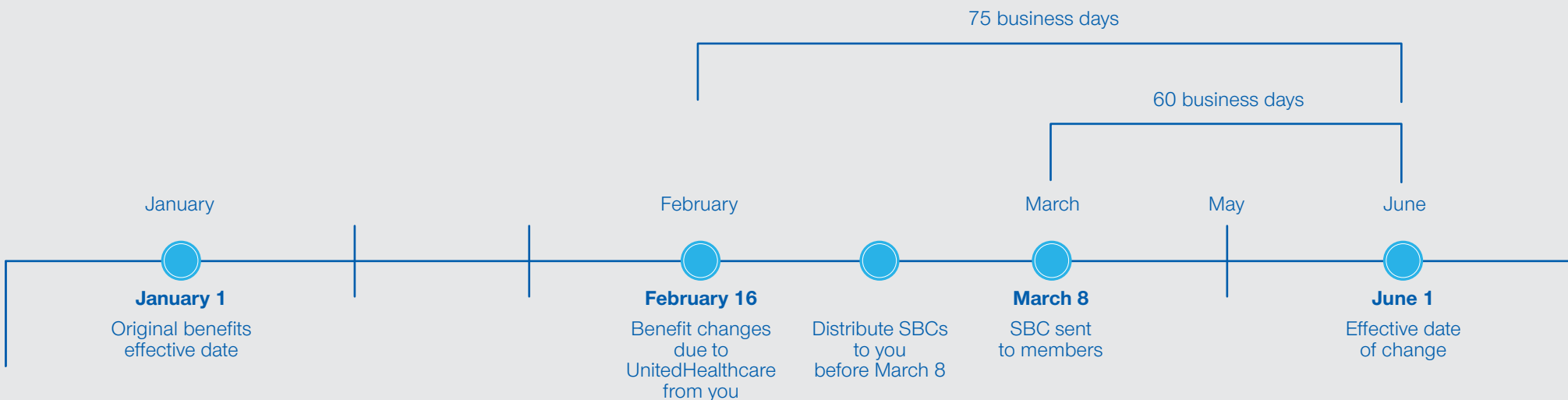
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Off-renewal

UnitedHealthcare will provide you the completed SBC electronically before the effective date of the change as long as we receive notification of benefit changes 75 business days in advance from you as an existing customer. Revised SBCs are required to be provided to members 60 days before the change.

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Small groups: SBC fulfillment process for member and employer fully insured group plans

UnitedHealthcare and the insured plan sponsor share joint responsibility for the generation and delivery of the SBCs to members. Please review the SBC member and employer fulfillment information for Small Group insured plans and UnitedHealthcare entity.

UnitedHealthcare’s Small Group Platform*

For members:

- A paper copy of the SBC is mailed to the member’s home address.
- The ability to access and view plan-specific SBCs on myuhc.com is currently not available. We are continuing to work towards SBC portal availability and will provide you with a notification when SBCs are available via myuhc.com for these members.

For employers:

- We will send a postcard to the employer notifying them that the SBC is accessible through the Employer eServices® (EeS) portal.

Groups Not Administered on UnitedHealthcare’s Small Group Platform

For members:

- We will continue to ask employers to distribute the SBC to members. A letter outlining the times throughout the plan year the employer should supply the SBC to members and new hires is provided with the SBC.

Groups (1-50 or 1-100)** on UnitedHealthcare Plan of the River Valley, Neighborhood Health Partnership, and UnitedHealthcare West

For employers:

- The SBC for each employer group is printed and mailed to the client contact.

* Please note that UnitedHealthcare’s Small Group Platform (PRIME) supports all UnitedHealthcare (1-50 or 1-100)** business and the smaller-sized Key Account clients as long as a standard plan design was sold.
**Small group size may change as a result of Protecting Affordable Coverage for Employees (PACE) Act (1-50 or 1-100)



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Did you know?

As a group health plan, you must make the Uniform Glossary available to participants and beneficiaries. If a copy is requested, it must be provided in the format required by the departments. This is to ensure the information is consistent and uses language that the average plan enrollee can understand. UnitedHealthcare will provide a link within your Employer Web portal to the Department of Labor (DOL) and Centers for Medicare & Medicaid Services (CMS) website so you can print copies for your employees.

2017 View Uniform Glossary
Final Glossary for use on or after 4/1/17

2016 View Uniform Glossary



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What is a material modification?

A material modification is any modification to the coverage offered under a plan that – independently or in conjunction with other modifications or changes – would be considered by an average plan participant or individual covered under a policy to be an important change in covered benefits or other terms of coverage under the plan or policy.

Important changes include:

- Elimination of benefits
- Reduction of benefits under the plan, including formulas, methodologies or schedules that serve as the basis for making benefit determinations
- Increases in benefits under the plan
- Increases in deductibles, coinsurance, copayments or other amounts to be paid by a participant or beneficiary
- Decreases in deductibles, coinsurance, copayments or other amounts to be paid by a participant or beneficiary
- Changes in state mandates for non-ERISA plans that are contained within the SBC
- Establishment of new conditions or requirements (for example, preauthorization requirements) for obtaining benefits under the plan

Off-renewal changes

Advance notice of material modification is required for a change that occurs other than in connection with a renewal. You must notify your members at least 60 calendar days before the effective date of the change, if the change affects information included in the SBC and is not reflected in the most recent SBC.

Other events that require SBC distribution:

Upon request

If a request is received, the SBC should be provided as soon as possible, but never later than seven business days.

When you have “special enrollees”

A special enrollee is a plan member who has a HIPAA Special Enrollment event, such as a marriage or birth of a child, or loss of other coverage. An SBC must be provided no later than when a summary plan description is required under the time frame set forth in ERISA, which is 90 calendar days from enrollment.



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Translation of SBCs

Final regulations require that the SBC be provided in a culturally and linguistically appropriate (CLA) manner. The CLA provision applies only to counties identified in the American Community Survey data provided by the U.S. Census Bureau report as having 10 percent or more of the population literate only in the same non-English language. UnitedHealthcare will provide members with translation services at no additional cost. For UnitedHealthcare members requesting oral translation services, we will follow the business model and utilize a vendor to facilitate where needed. Written translation will be provided for UnitedHealthcare created SBCs, upon request, for the languages required by the CLA provision.

The languages currently required are:

- Spanish
- Chinese
- Tagalog
- Navajo

To help plans and issuers meet the language requirements, HHS will provide written translation of the SBC template, sample language and Uniform Glossary.

American Community Survey (ACS) data

The SBC translation is the same as the current appeals translation requirements. [Click here](#) to determine if your group has any employees in the required counties.



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How you may provide it

Your SBC may be provided in paper form, online or by email.

Electronic transmission requirements

Electronic delivery for enrolled members is subject to DOL regulations on electronic disclosure. For more details about the DOL electronic disclosure requirements (29 CFR 2520.104b-1(c)) please [click here](#).

Your SBC can be provided electronically to members who are eligible for, but not enrolled in, coverage if the following conditions are met:

- 1 The format is readily accessible
- 2 A paper copy is provided free of charge upon request, and
- 3 If it is posted online, an email or paper form notification must be sent to the employee stating the SBC is available on the Internet*

* The notification must provide the Internet address and tell the member the document is available in paper form upon request.



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Accessing your SBC (for small groups on PRIME platform only)*

How to access your UnitedHealthcare created SBC

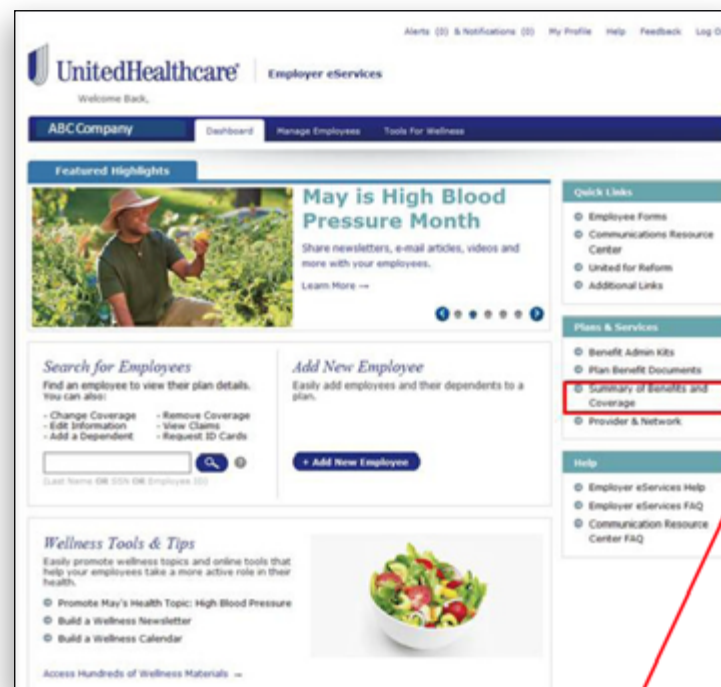
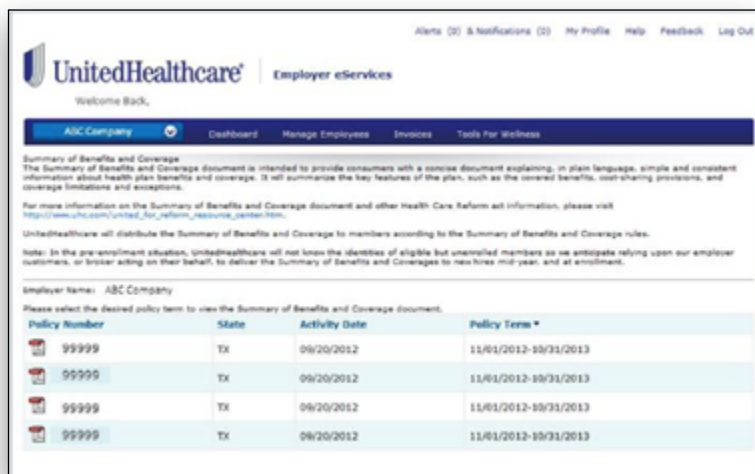
Employer groups (1-50 or 1-100)** on UnitedHealthcare’s small group platform will have the ability to view, access and print SBCs through the Employer eServices® (EeS) portal. We will send a postcard to the employer notifying them that the SBC is accessible through EeS.

* Please note that UnitedHealthcare’s small group platform (PRIME) supports all UnitedHealthcare (1-50 or 1-100)** business and smaller-sized Key Account clients as long as a standard plan design was sold.

**Small Group size may change as a result of Protecting Affordable Coverage for Employees (PACE) Act (1-50 or 1-100)

You can access SBCs by:

- 1 Logging into the UnitedHealthcare Employer portal
- 2 Entering your username and password
- 3 Selecting “Summary of Benefits and Coverage” under Plans & Services



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If you have requested UnitedHealthcare include external vendor information in the SBC, we will highlight the areas you will need to complete.

Full SBC (no external vendors)

The full SBC requires no activity on your part. UnitedHealthcare has completed the document because you use no external vendors, other than UnitedHealthcare or one of our sister companies.

Full SBC (including external vendor information)

If you have requested UnitedHealthcare include external vendor information in the SBC, some additional work is required on your part.*

You (or your vendor) will need to provide complete information in the following highlighted sections:

- Deductibles
- Out-of-pocket limits
- Prescription drug coverage
- Mental health benefits

- Calculated Coverage Examples
 - Plan Pays & Patients Pay (at the top of the example)
 - Patient Pays break out (bottom of the example)
 - Deductibles
 - Copayments
 - Coinsurance
 - Limits or exclusions
 - Total

Once you have completed those sections, please review and approve the document. You can then email your external vendor SBC to your Sales Account Executive to be included in the SBC installation process.

Partial SBC (excluding external vendor information)

If UnitedHealthcare provides your health claims administration but you use external vendors for other benefit services, we will create the SBC, including calculating coverage examples, for the services that you receive from UnitedHealthcare. You will be responsible for completing any information from outside vendors and completing the calculation of the coverage examples within the SBC document.

* Additional fees may apply for this service. Please see your Sales Account Executive for more information on fees and other SBC services available.



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Helpful links

Here are several links to government websites you may find helpful in answering questions you may have about the SBC process:

[Final regulations](#)

[Compliance](#)

[2017 Uniform Glossary](#)

Final Glossary for use on or after 4/1/17

[2017 Instruction guide](#)

[Electronic delivery](#)

[American Community Survey \(ACS\) data](#)



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