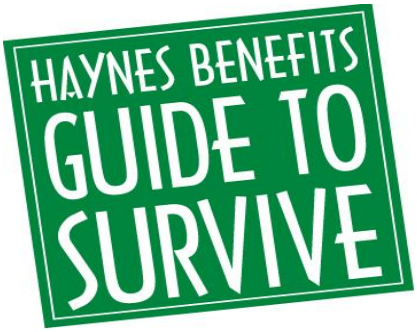

. . . Health Care Reform 2011

Uniform Standards for Health Plan Benefits and Coverage Summaries

The Affordable Care Act (the "Act") includes a mandate that HHS develop standards for summaries of benefits and explanations of coverage by group health plans and health insurance issuers. The summaries must not be longer than 4 pages and be in 12 point font. The summaries must use easy to understand language, uniform definitions and provide detailed information. They will apply to both grandfathered and non-grandfathered health plans and both insured and non-insured plans.

The new standards and summaries will be effective (presumably as of the first day of the plan year or policy year) beginning on or after March 23, 2012.

The Act prescribes that the summaries be presented in a "culturally and linguistically appropriate manner."

Specifically, the summary needs to include the following:

- uniform definitions of standard insurance and medical terms, so consumers can compare health insurance coverage and compare the terms of coverage;
- a description of essential health benefits coverage and other coverage;
- coverage exceptions, reductions and limitations;
- cost sharing provisions, including deductibles, coinsurance and co-pays;
- a coverage facts label that includes examples illustrating common benefit scenarios, such as pregnancy or chronic medical conditions as well as related cost sharing;
- a statement of whether the plan (1) provides minimum essential coverage and (2) ensures that its total allowed benefit cost under the plan is no less than 60% of these costs;
- a statement that the outline is a summary of the plan or policy and that consumers should consult the plan's coverage document to determine the plan's governing contractual provisions; and
- a contact number for additional questions and an internet web address where a copy of the actual coverage document can be reviewed and obtained.

The summary shall be updated periodically (probably annually).

The summary must be provided to:

1) an applicant at the time of the application;

2) an enrollee at the time of enrollment or re-enrollment; and

3) a policyholder or certificate holder at the time of the issuance of the policy or delivery of the certificate.

The entities referred to in the Act are specifically described as the health insurance issuer for insured coverage or the plan sponsor for self insured coverage.

Material modifications to the summary must be provided by notice to enrollees at least 60 days before the date the modification will be effective.

Failure to provide the information required shall be subject to a fine of not more than $1,000 for each failure and will be applied with respect to each enrollee.

May 12, 2011
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