UnitedHealthcare® Oxford

An 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.

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.

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.**

Overview

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, 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 Oxford created SBCs, we will support group health plans with determining whether the plan or coverage meets the MV requirements for the Oxford 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.

Overview

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

Other SBC distributions

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

Click on the buttons below to find out more

What we will do

Deadlines

Translation of SBCs

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.

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.

What we will do — Oxford fully insured group plans

For insured health plans, we and the Group Health Plan are jointly responsible for meeting the SBC requirements for creation and delivery of the SBCs to members.

Groups on the small (1-50 or 1-100)** platform:

Employer groups (1-50 or 1-100) enrolled through Idea Management System℠ (IDEA) will have the ability to view, access and print SBCs through the Employer portal of oxfordhealth.com **(see guide section Accessing Your SBC)**. We will continue to ask employers to distribute SBCs to members.* Their members will also have the ability to view and print the SBC(s) from the Member portal of oxfordhealth.com.

Groups on the large (51+ or 100+) platform:

For large groups, we send the SBC by email to the main contact at the employer group. We will continue to ask employers to distribute SBCs to members. A letter outlining the times throughout the plan year that the employer should supply the SBC to members and new hires is emailed with the SBC. For large groups, viewing an SBC online and member fulfillment of SBCs through electronic delivery will not be available.

If you use an external vendor for certain benefits

If we provide your Oxford medical insurance coverage, but you use external vendors for other benefit services, we will create the SBC, including calculating coverage examples, for the Oxford services that you insure through us. You will be responsible for completing any information from outside vendors and completing the calculation of the coverage examples within the SBC document. We can only make requested benefit change updates to the SBC going forward for the Oxford services that we provide you.

Plans excluded from the SBC requirements include:

- Retiree-only
- Stand-alone dental or vision

*All assumed renewal plan SBCs will be made available through IDEA and the Employer portal of oxfordhealth.com within 60 days of your renewal date. If, for any reason, the assumed renewal SBC is not successfully loaded to IDEA or the Employer portal, a hard copy will be mailed within 30 days of your renewal date. The information related to when you must provide the SBCs to your members is found directly on IDEA and the Employer portal.

**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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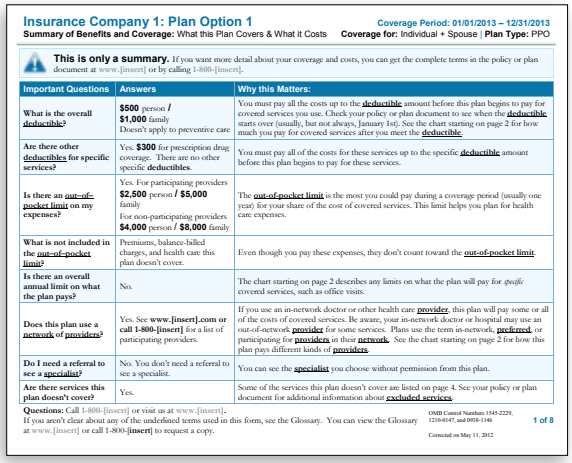
What we will do — Oxford fully insured group plans

2012 SBC template



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 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
Corrected on May 11, 2012

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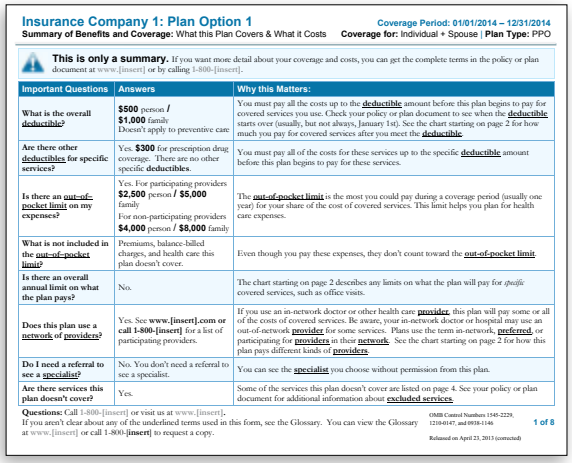
2013 SBC template



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

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
Released on April 23, 2013 (corrected)

1 of 8

2017 SBC template

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

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

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What we will do — Oxford fully insured group plans

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.

At renewal | **Prior to renewal** | **Off-renewal**

* 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.

What we will do — Oxford fully insured group plans

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**
  We will provide the completed Oxford 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**
  We will provide the completed Oxford 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 Oxford 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

DEADLINES MAIN PAGE

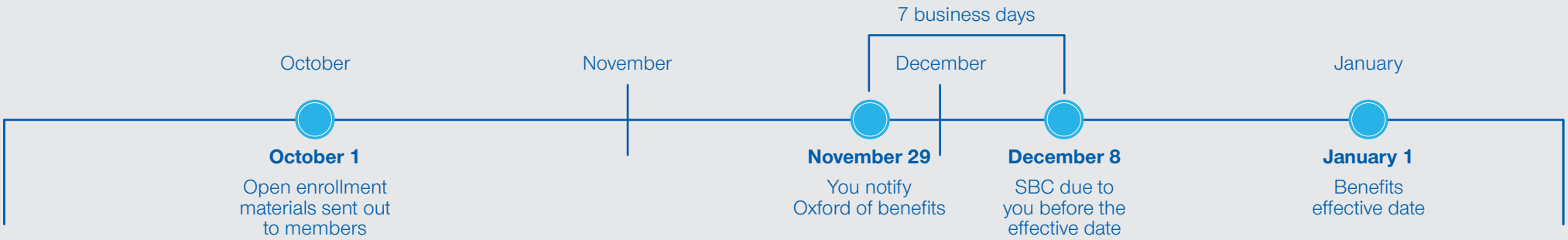
What we will do — Oxford fully insured group plans

Prior to renewal (changes between open enrollment and renewal)

If you have changes prior to renewal, but after distribution of the first Oxford SBC, we 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

DEADLINES MAIN PAGE



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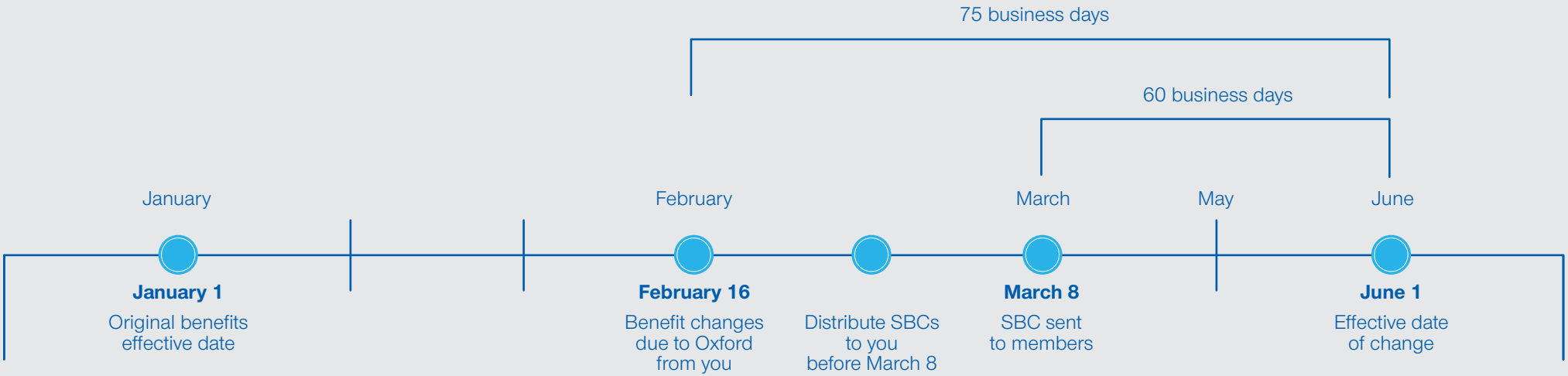
What we will do — Oxford fully insured group plans

Off-renewal

We will provide you the completed Oxford SBC electronically before 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.

Sample timeline

DEADLINES MAIN PAGE



What we can help with — Oxford self-funded group plans

You or your designated administrator are responsible for meeting the SBC requirements for self-funded plans.

Upon request (at no additional cost), we will be prepared to:

- Create the SBC for the Oxford services we administer;
- Put it in the uniform format outlined by the ACA and its implementing regulations;
- Calculate and include the coverage examples in your SBC;
- Deliver the SBC electronically to you; and
- Update the Oxford services information on the SBC going forward whenever you request a benefit change.

You will be responsible for delivery of SBCs to members.

If we provide your Oxford health claims administration but you use external vendors for other benefits services, we will create the SBC, including calculating coverage examples, for the Oxford services that you receive from us, upon request. You will be responsible for completing any information from outside vendors and completing the calculation of the coverage examples within the SBC document. We can only make requested benefit change updates to the SBC going forward for the Oxford services that we provide you.

Plans excluded from the SBC requirements include:

- Retiree-only
- Stand-alone dental or vision

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What you will need to do — Oxford self-funded group plans

As a self-funded plan sponsor, you are responsible for creating and distributing the SBC. As your health claims administrator, we will be prepared to create, calculate and deliver an Oxford SBC electronically for those services we administer, upon request.

The following is a breakdown of who gets your SBC and when. We have also included details on how you may provide it to your plan members along with information on how you can initially access your SBC once we have completed our portion.

Who gets your SBC

How you may provide it

When they get it

Accessing your SBC

Did you know?

As a group health plan sponsor, 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.

We will provide links within the Employer portal of oxfordhealth.com to the Department of Labor (DOL) and Centers for Medicare & Medicaid Services (CMS) websites so you can print copies for your employees. We will refer the member back to you for a paper copy of the Uniform Glossary.

VIEW 2017 UNIFORM GLOSSARY
Final Glossary for use on or after 4/1/17

VIEW 2016 UNIFORM GLOSSARY

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What you will need to do — Oxford self-funded group plans

Who gets your SBC

Your SBC must be provided to both eligible members and their dependents. For new enrollees, an SBC needs to be provided for each plan in which the member is eligible to be enrolled. For members currently enrolled in a plan, only the SBC for the plan in which they are enrolled must be provided.

You can send a single SBC to an employee and his or her dependents, if they are all living at the same address. However, if any beneficiaries live elsewhere, you need to be sure they also receive an SBC.

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What you will need to do — Oxford self-funded group plans

When they get it

You must provide an SBC in these situations:

- First day of open enrollment (members)
- At renewal
- Off-renewal changes
- Upon request
- Special enrollees

First day of open enrollment

- The SBC must be provided as part of any written application materials that are distributed by the plan for enrollment.
- If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date on which the participant is eligible to enroll in coverage for the participant and/or any beneficiaries.

At renewal

How and when SBCs should be provided at renewal depends on several factors:

1. When a reapplication is required

   If written applications are required for renewal (paper or online), the SBC must be provided no later than the date on which the materials are distributed.

2. Automatic renewal

   The SBC Final Rule states that, in general, if a renewal or reissuance of coverage does not require reapplication, the SBC must be provided no later than 30 calendar days before the first day of the new plan year. If members are eligible to change coverage elections during an annual open enrollment period, the SBC must be provided with the open enrollment materials.

3. SBC change

   If any plan changes reflected in the SBC are made after the initial SBC is distributed, but before the first day of coverage, an updated SBC must be provided no later than the first day of coverage.

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What you will need to do — Oxford self-funded group plans

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 in advance of 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.

What you will need to do — Oxford insured and self-funded group plans

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. We will provide members with translation services at no additional cost. For Oxford 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 Oxford 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, the Department of Health and Human Services (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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What you will need to do — Oxford insured and self-funded group plans

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 Department of Labor (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.

What you will need to do — Oxford insured and self-funded group plans

Accessing your SBC

How to access your Oxford-created SBC

Employer groups (1-50 or 1-100)* enrolled through IDEA will have the ability to view, access and print SBCs through the Employer portal of oxfordhealth.com. Members will have the ability to view, access and print SBCs through the Member portal of oxfordhealth.com. For large groups, viewing an SBC online and member fulfillment of SBCs through electronic delivery will not be available.

*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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Other resources

If we provide all of your benefit services and you use no external vendors, other than Oxford there will be no action required on your part for finalizing the SBC. Your SBC from Oxford will be complete. If, however, you use external vendors for other benefit services, as previously mentioned, you will be responsible for completing any information from outside vendors and completing the calculation of the coverage examples within the SBC document.

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**