Hello!

This issue of the eUpdate focuses on two important provisions of healthcare reform: the Summary of Benefits and Coverage document, and women's preventive care coverage. We hope you find this information valuable.

**SBC Documents to Replace Medical Benefit Summaries**

In compliance with healthcare reform, PacificSource will begin loading summary of benefits and coverage (SBCs) for our current groups and individual policyholders to InTouch (our secure online portal) **September 4, 2012**. We will have them all posted by September 23, 2012 based on the benefits and eligibility set-up for that policyholder as of that date.

Please note that these **will replace the medical benefit summaries you are accustomed to seeing on InTouch**. One of the major differences between our current benefit summaries and the SBC is that in the SBC, benefits are listed as the member's cost-share instead of the PacificSource benefit level.

**What is an SBC?**
The SBC is a document intended to help consumers better understand their healthcare options by illustrating benefits in a standardized format. Beginning September 23, 2012, the Affordable Care Act requires group health plans and insurers to provide an SBC to policyholders, subscribers, dependents, and applicants.

SBCs are required for commercial group (both fully insured and self-insured), individual medical insurance policies, and HRAs. The SBC is not required for Medicare Advantage, Medicaid, and dental-only policies (other than pediatric dental). Note that while dental-only coverage is not subject to SBC requirements, we have reformatted the benefit summary in our dental-only handbooks to be consistent with the SBC by showing the member's cost-share.

**Questions and Answers**
If you have questions about the SBC, you're definitely not
alone. That's why we've developed a new FAQ document, which we encourage you to read. As implementation requirements are changed or clarified, we will continue to update the FAQ. If you have any additional questions, you're welcome to contact your Provider Service Representative.

Women's Preventive Care Timeline and Caveats

One of the most talked-about pieces of the Affordable Care Act is the women's preventive care provision. Basically, the law now makes many women's healthcare services available with no cost sharing (deductible, co-payment, and co-insurance waived) through participating providers. As with other aspects of healthcare reform, however, it's important to understand how this provision will be implemented. Here are a few key things to keep in mind:

Effective dates

- For individual policies in Oregon and group policies in all states, the changes are effective on the plan's first renewal date on or after August 1, 2012; i.e., it could be as late as July 1, 2013, for some plans.
- For Montana and Idaho individual policies, the changes became effective across the board for all plans on August 1, 2012.

Grandfathered plans
The provision does not apply to grandfathered groups unless they previously accepted the ACA preventive care changes.

Contraceptives
What's covered at no cost:

- Generics
- Preferred/formulary if generic is not available

What's subject to co-pay, co-insurance, and/or deductible as indicated on the member's pharmacy benefit summary:

- Preferred/formulary if generic is available

Providers
Nonparticipating providers (providers not in our network) will continue to be subject to any applicable deductible, co-payment, or co-insurance.

Learn More about Reform
Our Healthcare Reform Resource Center contains FAQs, timelines, additional resources, and more. Visit our Healthcare Reform Resource Center to learn more.