CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Tools for Assisters and Consumers: Summary of Benefits and Coverage

May 2, 2014

Summary of Benefits & Coverage

- Purpose:
  - Allows consumers to make “apples-to-apples” comparisons when you’re looking at different plans.
- What it is:
  - An easy-to-understand summary about a health plan’s benefits and coverage.
  - All individual and group health plans must use the same standard form to help compare plans and provide it to consumers prior to enrollment, at renewal, and anytime upon request, for example.

Summary of Benefits & Coverage

Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014

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.

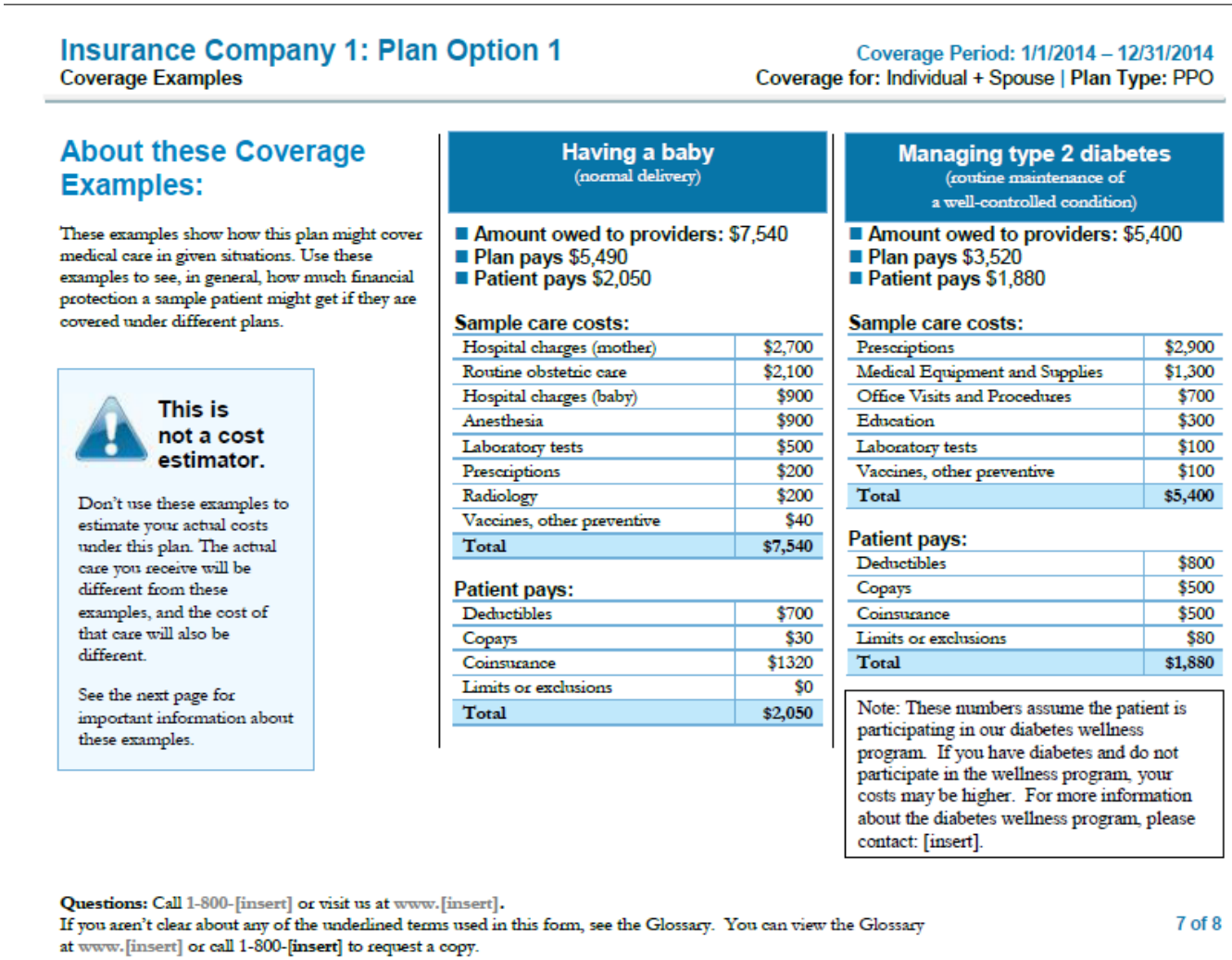
OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Released on April 23, 2013

Coverage Examples

- Standardized health plan comparison tool, modeled on the Nutrition Facts label required for packaged foods.
- Illustrate, for comparison purposes, what proportion of the cost of care a health insurance policy or plan would cover for a sample patient for two common medical situations
  - Having a baby
  - Managing type 2 diabetes

Coverage Examples



Insurance Company 1: Plan Option 1
Coverage Examples

Coverage Period: 1/1/2014 – 12/31/2014
Coverage for: Individual + Spouse | Plan Type: PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in 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 $5,490
- Patient pays $2,050

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	$700
Copays	$30
Coinsurance	$1320
Limits or exclusions	$0
Total	**$2,050**

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

- Amount owed to providers: $5,400
- Plan pays $3,520
- Patient pays $1,880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$800
Copays	$500
Coinsurance	$500
Limits or exclusions	$80
Total	**$1,880**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [insert].

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.

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Uniform Glossary

- Provides consumer friendly definitions for common health coverage and medical terms.
- Static document that is uniform across all plans and issuers.
- Assisters and consumers may access the document at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf

Uniform Glossary

Glossary of Health Coverage and Medical Terms

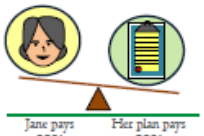
- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may *not* balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance *plus* any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

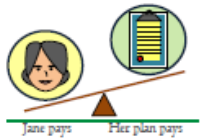


(See page 4 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

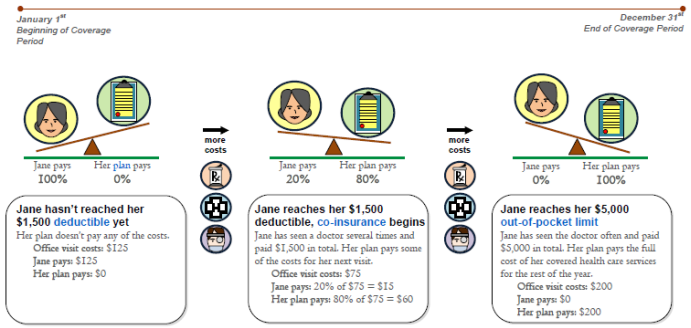
Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance: 20%** **Out-of-Pocket Limit: $5,000**



Who Gets an SBC?

- Consumers shopping for coverage.
- Employers shopping for coverage to offer to their employees.
- Employees choosing among employer-based coverage options.
- Individuals and dependents currently covered by an individual market policy.
- Employers currently under contract with an insurance issuer or third party administrator.
- Participants and beneficiaries currently covered by an employer plan.

When & How Can Consumers Get an SBC?

- Consumers have the right to get an SBC when shopping for, enrolling in, or renewing coverage.
- The SBC is available for every plan in the Marketplace. Consumers will find a Web link to it on each plan page when they enroll through HC.gov.
- Consumers also have a right to receive an SBC from their insurance company or group health plan upon request at any time.
- Consumers may be able to request an SBC in Spanish, Chinese, Tagalog, or Navajo.

When & How Assisters Can Help a Consumer Use an SBC

Plan Comparison and Selection Process

- To compare plans when shopping for coverage

After Enrollment

- To understand benefits once enrolled in coverage

Where to Access an SBC When Shopping for Coverage