Understanding the Summary of Benefits and Coverage (SBC) Fast Facts for Assisters

This Fact Sheet Provides Guidance to Help Assisters:

- Interpret the Summary of Benefits & Coverage (SBC) for health plans
- Assist consumers with using the SBC to compare health plan benefits

Summary of Benefits & Coverage: Overview

To help consumers compare the different features of health benefits and coverage, the Affordable Care Act generally requires all group health plans and health insurance companies to provide individuals a "summary of benefits and coverage" that "accurately describes the benefits and coverage under the plan." To fulfill this requirement, health plans generally must provide a Summary of Benefits & Coverage (SBC).

The SBC is a snapshot of a health plan's costs, benefits, covered health care services, and other features that are important to consumers. SBCs also explain health plans' unique features like cost-sharing rules and include significant limits and exceptions to coverage in easy-to-understand terms. Along with the SBC, group health plans and health insurance companies must also provide a *Uniform Glossary* to explain common medical and insurance-related terms. **This fact sheet focuses on the SBC provided by health insurance companies that offer coverage through the Marketplaces. The sample SBC used below is for illustrative purposes only and is not intended to reflect any Marketplace plan option.**

What Assisters Need to Know About Locating the SBC

As consumers compare qualified health plans (QHPs) offered through the Marketplaces, you can help them figure out the benefits offered in each plan by walking them through the SBC. Consumers may access the SBC within each health plan's detailed view on HealthCare.gov. Exhibit 1 shows an example of a health plan's detailed view, which allows consumers to learn more about a health plan before they enroll in the plan.

Exhibit 1 - Health Plan Details with SBC

What Assisters Need to Know When Reviewing the SBC with Consumers

Assisters should help consumers understand that all SBCs consist of the following basic parts:

- **Important Questions:** Consumers can use this section to answer their questions about some of the health plan's costs, including deductible amounts and out-of-pocket limits. This section also contains information on coverage for in-network and out-of-network providers.
- **Common Medical Events:** This section provides information about the cost-sharing (such as co-payments or coinsurance) and significant limitations or exclusions for certain common medical events. Services described include a visit to a provider's office, having an MRI or CAT scan, having a hospital stay, and prescription drug information.
- **Excluded Services and Other Covered Services:** Consumers can refer to this section to learn about certain services that are not covered by their health plan, as well as some additional services the plan does cover.
- **Coverage Examples:** Each SBC will include examples of how the plan might cover a hypothetical consumer's health care costs for sample health conditions, such as pregnancy or type 2 diabetes. Consumers should not use the coverage examples to estimate their actual costs under the plan. This is because the actual services and costs would depend on the consumer's particular medical needs, as determined in consultation with a provider. Rather, they should use the examples to generally see how much

financial protection the plan is expected to provide for these sample health conditions. Looking at these standardized, hypothetical coverage examples can help facilitate apples-to-apples comparisons between plans.

- **Uniform Glossary:** Each SBC contains a link to a glossary with consumer-friendly explanations of common medical and insurance terms, such as “deductibles” and “premiums.” All health insurance issuers use the same glossary.

Be sure to remind consumers that they can use the SBC to answer their general questions about a health plan before selecting a plan for enrollment. For information about their specific health services and how their plan can help them pay for these services, consumers can contact the insurance company and should review the insurance policy closely. You should also remind consumers that their benefits and coverage under a health plan may change during the benefit year, although this is not common, or when a new benefit year begins, which is very common. If a change to the information on the SBC occurs in the middle of the benefit year the health insurance company must notify the consumer of the change at least 60 days before the change goes into effect. Before a new benefit year begins, the consumer should expect a new SBC from the health insurance company which reflects changes to the information on the SBC that will be in effect for the plan in the new benefit year.

Scenario: Using the Summary of Benefits to Help a Consumer Choose a Health Plan

Ella, a 28-year-old consumer, wants to enroll in a health plan for herself and her husband for the first time. With your help, Ella has submitted an eligibility application and was determined eligible to purchase a QHP through the Marketplace. Ella informs you that she has chronic back pain and her husband suffers from asthma. She has picked out a plan that she believes will provide good coverage for her and her husband’s conditions; however, Ella is concerned about needing back surgery this year, in addition to the out-of-pocket costs for prescription drugs and the costs she may be responsible for if she visits a specialist who is outside of the plan’s network. To assist her, you direct Ella to the health plan’s SBC to help her find answers to her specific questions. As you assist Ella, she asks you following questions:

1. *My last doctor said I might need to have in-patient back surgery in the next year. Do I need to get a referral to see a back specialist?*

   First, direct Ella to the Important Questions chart of the SBC. One important question and answer on this chart shows whether Ella would need a referral before she sees a specialist. Note to her that it is common for plans that are PPOs like this one to not require a referral to see a specialist, unlike HMO plans for which referrals are more commonly required. A sample Important Questions chart is shown below in Exhibit 2.

Exhibit 2 – Sample Important Questions Chart

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.

2. *If I do need surgery, how much will it cost me to have a surgery on this plan?*

   You should inform Ella that the SBC cannot provide the exact costs she will pay for a complicated episode of care like back surgery. Her actual services and costs would depend on her particular medical needs, as determined in consultation with her provider. However, you can show her two sections of the SBC that can help Ella determine her potential cost-sharing for services she will receive if she gets back surgery. First, again, direct Ella to the *Important Questions* chart of the SBC. Explain that the deductible amount in the first row is the amount that Ella must meet before the insurance company will begin to pay for covered services. In this example, the plan has a $500 per person deductible, and a $300 specific deductible for prescription drug coverage.

   Second, direct Ella to the *Common Medical Events* chart, shown in Exhibit 3 below,

which starts on the next page of the SBC. This chart will help Ella determine her potential portion of the costs (cost sharing) for different health care services for which she would be responsible after she has met her plan's deductible(s). For example, the cost sharing of an office visit with a specialist is $50/visit for a participating provider in the plan's network, which means that Ella would need to pay $50 each time she visits an in-network (participating) specialist. The cost sharing is 40% coinsurance for an office visit with a nonparticipating provider that is not in the plan's network. This means that Ella would need to pay 40% of the allowed amount for the visit. For example, if the plan's allowed amount for an out-of-network (nonparticipating) specialist visit is $200, her coinsurance payment of 40% would be $80. This may change if she has not met her deductible.

Ella should also pay attention to the "if you have a test" row of the Common Medical Event chart to determine the potential cost sharing for having an imaging test performed, like an MRI or CT/PET scan. Another service Ella may need is contained in the rows in the Common Medical Event chart titled, "if you have outpatient surgery" or "if you have a hospital stay." Either of these rows may apply, depending on whether her surgery would be performed in an outpatient or inpatient setting.

For the most accurate information about the specific services Ella is interested in you can also direct her to use the contact information at the top of the first page of the SBC to access or request a copy of the actual plan or policy document which will provide detailed information about specific benefits covered under the plan. See Exhibit 4.

Exhibit 3 - Sample Page from Common Medical Events Chart

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	40% coinsurance	none
	Specialist visit	$50 copay/visit	40% coinsurance	none
	Other practitioner office visit	20% coinsurance for chiropractor and acupuncture	40% coinsurance for chiropractor and acupuncture	none
	Preventive care/screening/immunization	No charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test	40% coinsurance	none
	Imaging (CT/PET scans, MRIs)	$50 copay/test	40% coinsurance	none
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].	Generic drugs	$10 copay/ prescription (retail and mail order)	40% coinsurance	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% coinsurance (retail and mail order)	40% coinsurance	none
	Non-preferred brand drugs	40% coinsurance (retail and mail order)	60% coinsurance	none
	Specialty drugs	50% coinsurance	70% coinsurance	none
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	none
	Physician/surgeon fees	20% coinsurance	40% coinsurance	none
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	none
	Emergency medical transportation	20% coinsurance	20% coinsurance	none
	Urgent care	20% coinsurance	40% coinsurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	none
	Physician/surgeon fee	20% coinsurance	40% coinsurance	none

Exhibit 4 – Sample Contact Information for More Details about 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

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3. *All of these services and costs seem to be adding up quickly! Is there any protection for me in this plan if I have to pay a lot out-of-pocket in one coverage year?*

   To answer this question, return to page 1 and find the row for "Is there an out-of-pocket limit on my expenses?" The out-of-pocket limit, as explained in the Uniform Glossary, is the most Ella could pay during a policy period (usually a year) before her health insurance company begins to pay 100% of the allowed amount. In this example, if Ella spends over $2,500 for services from in-network (or participating) providers, the health

insurance company will begin to pay 100% of the allowed amount. As the SBC shows, this limit never includes premiums, balance-billed charges or health care the health insurance company doesn't cover. Some health insurance companies don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

4. *Thanks! Hmm, now that I know how to interpret the cost-sharing features of a plan using the SBC, maybe I should look at another SBC to see how this plan matches up to another plan I was considering earlier.*

   Tell Ella that using the SBC to make apples-to-apples comparisons easier is exactly one of the main purposes of the SBC. If she doesn't have ready access to the other SBC, she can always request it from the insurance company and receive it within seven business days.

Additional Resources

For more information visit:

- **CMS**: Summary of Benefits and Cvoerage
  Available at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html

- **HealthCare.gov**: Overview of Summary of Benefits and Coverage
  Available at: https://www.healthcare.gov/how-does-the-health-care-law-protect-me/summary-of-benefits-and-coverage/

NOTE: CMS includes links to other Federal government Web sites and in some instances non-government Web sites. We provide these links because they contain additional information that may be useful or interesting and is consistent with the intended purpose of Marketplace.cms.gov. We cannot attest to the accuracy of information provided by these third-party sites or any other linked site. We are providing these links for your reference. Linking to a non-Marketplace.cms.gov Web site does not constitute an endorsement by CMS or any of its employees of the sponsors or the information and products presented on the Web site. Also, please be aware that the privacy protection provided on Marketplace.CMS.gov does not apply to these third-party sites.

- **Consumers Union:** Summary of Benefits & Coverage
  Available at: http://www.consumerreports.org/health/resources/pdf/SBCinfo.pdf

- **United Healthcare:** Healthcare Reform Summary of Benefits & Coverage (video)
  Available at: http://bcove.me/byimry8v