

EXPLAINING HEALTH CARE REFORM: SUMMARY OF BENEFITS AND COVERAGE AND THE UNIFORM GLOSSARY

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- The Accountable Care Act requires that health insurance carriers and employer-sponsored health plans provide a Summary of Benefits and Coverage (“SBC”) to participants and enrollees.
- Proposed regulations and templates on the SBC and Uniform Glossary were published on August 22, 2011.
- The Act originally required that plans begin using the SBC on March 23, 2012.
 - *The proposed regulations recognize that a mid-year communication requirement may be problematic for employers and sought comments on a phased approach to the rule.*
- Employers who sponsor self-funded plans will be responsible for the production and distribution of the SBC.

The Press Release

- Under the new rules, health insurers and group health plans will provide consumers with clear, consistent and comparable information about their health plan benefits and coverage.
- Today's proposal is a common-sense step that will help workers quickly and easily compare different coverage options, in order to make more informed decisions.
- Often, health plans and issuers only provide selective details on the plan or policy before it's purchased, giving consumers a limited understanding of what they are buying. The proposed rules give consumers straightforward, standardized information on their choices upfront, helping them understand the key features of the policy or plan and allowing them to make a more informed decision.
- The summary will use a uniform glossary to replace the jargon that makes it impossible to compare plans or figure out what is covered.



- The SBC is a written summary of benefits and coverage that is intended to help participants and beneficiaries make health care decisions and comparisons.
- The SBC is intended to assist plan sponsors in comparing and selecting health care coverage for employees.
- Under the proposed regulations, the SBC is a disclosure document that is separate from the SPD.
 - *SPDs must continue to be issued for GHPs.*

Contents of the Summary of Benefits

- Uniform definitions of standard insurance terms and medical terms.
- Description of coverage, including cost sharing, for each category of benefits identified by HHS.
- Exceptions, reductions, limitations on coverage.
- Cost-sharing provisions, including deductibles, coinsurance and copayments.
- Renewability and continuation of coverage provisions.
- Coverage examples (currently required in the template are: having a baby, treating breast cancer and managing diabetes, and how the coverage would apply under the plan).

Contents of the Summary of Benefits


- Premiums (fully-insured GHPs) or cost of coverage (self-insured GHPs).
- Contact information for questions and obtaining a copy of the plan document.
- Internet addresses for participants to obtain a list of network providers, information on prescription drug coverage, & access to the Uniform Glossary.
- A statement that the SBC is only a summary and the provisions of the plan document or insurance contract govern.
- Starting January 1, 2014, a statement regarding whether the plan provides minimum essential coverage and whether the plan's share of total allowed costs of benefits meets applicable minimum essential coverage requirements.

The Contents of the Summary of Benefits

- The proposed regulations set forth content, appearance, form and language requirements for SBCs.
- Use of the templates satisfies the content and appearance requirements.
- Plan sponsors of self-funded plans may need to modify the template, as the preamble to the regulations indicates that the SBC template and related documents were drafted primarily for use by health insurance carriers.

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

Policy Period: _____ - _____
Coverage for: _____ | Plan Type: _____


 **This is not a policy.** You can get the policy at www.insurancecompany.com/PLAN1500 or by calling 1-800-XXX-XXXX. A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why this Matters:
What is the premium?	\$	The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible?	\$	
Are there other deductibles for specific services?	\$	
Is there an out-of-pocket limit on my expenses?	\$	
What is not included in the out-of-pocket limit?		
Is there an overall annual limit on what the insurer pays?		
Does this plan use a network of providers?		
Do I need a referral to see a specialist?		
Are there services this plan doesn't cover?		

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

_____: _____
Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: _____ – _____
Coverage for: _____ | **Plan Type:** _____

-  **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your co-insurance payment of 20% would be \$200. If you haven't met any of the deductible and it's at least \$1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness			
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
More information about drug coverage is at www.insurancecompany.com/prescriptions	Specialty drugs (e.g., chemotherapy)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need	Emergency room services			

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
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_____: _____
Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: _____ - _____
Coverage for: _____ | **Plan Type:** _____

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
immediate medical attention	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you become pregnant	Prenatal and postnatal care			
	Delivery and all inpatient services			
If you have a recovery or other special health need	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
If your child needs dental or eye care	Hospital service			
	Eye exam			
	Glasses			
	Dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

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Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
 If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

_____: _____
Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: _____ - _____
Coverage for: _____ | **Plan Type:** _____

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

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Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

Your Grievance and Appeals Rights:

- A **grievance** is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit www.XXXXXXXXXXXXXX.com.
- An **appeal** is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit www.XXXXXXXXXXXXXX.gov.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the **Glossary** at www.insuranceterms.gov.

Coverage Examples

Policy Period: _____ - _____
 Coverage for: _____ | Plan Type: _____

About these Coverage Examples:

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much insurance protection you might get from 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 also will be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$10,000
- Plan pays \$
- You pay \$

Sample care costs:

First office visit	\$100
Radiology	\$300
Laboratory tests	\$200
Routine obstetric care	\$2,000
Hospital charges (mother)	\$4,100
Hospital charges (baby)	\$1,900
Anesthesia	\$1,000
Circumcision	\$200
Vaccines, other preventive	\$200
Total	\$10,000

You pay:

Deductibles	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$

Treating breast cancer (lumpectomy, chemotherapy, radiation)

- Amount owed to providers: \$98,000
- Plan pays \$
- You pay \$

Sample care costs:

Office visits & procedures	\$4,000
Radiology	\$4,000
Laboratory tests	\$2,400
Hospital charges	\$3,300
Inpatient medical care	\$200
Outpatient surgery	\$3,400
Chemotherapy	\$64,000
Radiation therapy	\$13,000
Prostheses (wig)	\$500
Pharmacy	\$2,000
Mental health	\$1,200
Total	\$98,000

You pay:

Deductibles	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$

Managing diabetes (routine maintenance of existing condition)

- Amount owed to providers: \$7,800
- Plan pays \$
- You pay \$

Sample care costs:

Office visits & procedures	\$960
Laboratory tests	\$300
Medical equipment & supplies	\$40
Pharmacy	\$6,500
Total	\$7,800

You pay:

Deductibles	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$

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Coverage Examples _____ : _____

Policy Period: _____ - _____
Coverage for: _____ | Plan Type: _____

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy period.
- There are no other medical expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- * **No.** Treatments shown are just examples. The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- * **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Providing the SBC to Plan Sponsors

- Insurers/carriers are required to provide an SBC to the plan sponsor upon application or request for information.
- The SBC must be provided as soon as practicable following the request, but in no event later than seven days.
- An insurer/ carrier also must provide a new SBC to the plan sponsor each year when the policy is renewed (if renewal is automatic, the SBC must be provided at least 30 days prior to renewal).

Providing the SBC to Plan Participants

A group health plan or health insurance carrier must provide an SBC to:

- participants or beneficiaries upon request, as soon as practicable, but in no event later than seven days following the request;
- special enrollees within seven days of a request for enrollment pursuant to a special enrollment right under HIPAA; and
- a participant or beneficiary with respect to each benefit option for which the participant or beneficiary is eligible no later than the first date the participant is eligible to enroll (or with any written application materials distributed prior to enrollment).
 - On renewal, an SBC only has to be provided for the benefit option which a participant is enrolled (unless SBCs for other options are requested).

Providing the SBC to Plan Participants

- If there is any change to the information required to be in the SBC before the first day of coverage, the plan or carrier must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.
- A group health plan or health insurance carrier also must provide participants with a new SBC each year when the policy is renewed (if renewal is automatic, the SBC must be provided at least 30 days prior to renewal).
- The SBC requirement is satisfied if a single SBC is provided to a participant and beneficiary known to reside at the same address.
- The SBC requirement may be satisfied electronically, provided the distribution complies with ERISA's electronic disclosure rules.

Uniform Glossary

- According to the “Healthcare.gov” factsheet - Under the proposed regulations, consumers will have a new tool to help them understand some of the jargon that makes it impossible to figure out what is covered and how one insurance plan stacks up compared to another.
- To allow apples-to-apples comparison, terms would be the same across all plans. Insurance companies and group health plans will be required to make available upon request a uniform glossary of terms commonly used in health insurance coverage such as “deductible” and “co-pay”.
- The glossary is available at:
<http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf>

Glossary of Health Insurance and Medical Terms

- This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate. You can get a copy of the policy at [www.insurancecompany.com] or you may call [1-800-xxx-xxxx].
- **Bold** 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

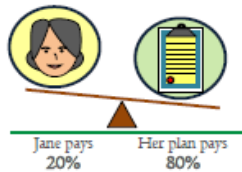
A request for your health insurer or **plan** to review a decision or a **grievance** again.

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.

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.

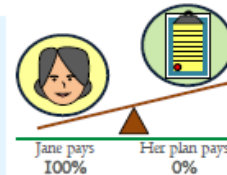
OMB Control Numbers 1545-XXXX,
1210-XXXX, and 0938-XXXX
(expires XX/XX/XXXX)

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 received in an emergency room.

Emergency Services

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

Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance

A complaint that you communicate to your health insurer or **plan**.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care

Health care services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to providers who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network

The facilities, providers and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or **plan**, or if your health insurance or **plan** has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance

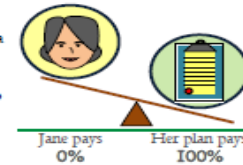
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, balance-billed charges or health care your health insurance or **plan** doesn't cover. Some health insurance or **plans** don't count all of your co-payments, deductibles, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage

Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care

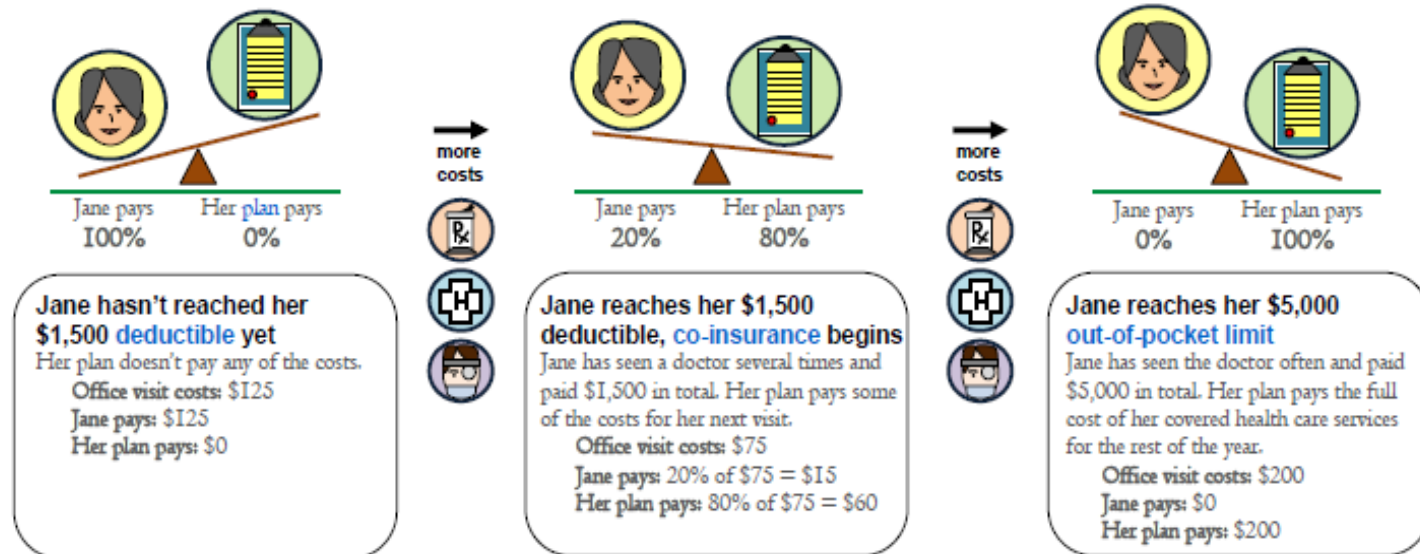
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

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

January 1st
Beginning of Policy Period

December 31st
End of Policy Period



Notice of Material Modification

- If there is a material change to the benefits or coverage in the SBC during the plan year, insurance issuers and GHP sponsors must provide notice of the change not later than 60 days prior to the date on which the change will become effective.
 - a material change (or modification) is a change that affects the content of the SBC, including enhancements or reductions of covered services or benefits.
- The proposed guidance indicates that notices of material modifications will only have to be provided in situations other than open enrollment, renewal or reissuance.
 - For example, if the material modification coincides with the start of a new plan year, then only the required SBC (that includes the modified information) must be provided to participants and beneficiaries; not the notice.

QUESTIONS