Guide to the Summary and Benefits of Coverage

The Affordable Care Act (ACA) makes health insurance available to nearly all Americans. Beginning in 2014, each state will have a new health insurance marketplace, also known as a health insurance exchange, where people who do not have other sources of insurance can purchase an individual or family policy.

Plans sold in the marketplace (officially known as qualified health plans) will have to publish a Summary of Benefits and Coverage document that describes covered benefits and cost sharing in the plan. This tool walks you through the Summary of Benefits and Coverage to help you better understand and compare benefits across plans you are considering.

NOTE: The purpose of this tool is to describe the Summary of Benefits and Coverage document and the plan information it provides. Each person should make an independent decision about his/her selection of a plan based on individual circumstances and adequacy of coverage in consultation with trusted advisors. Other information is available through your state's marketplace.

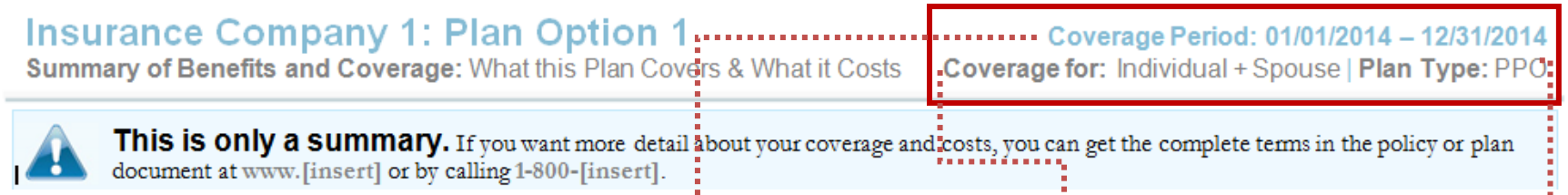
This tool uses screenshots from a sample Summary of Benefits and Coverage document released by the federal government. The costs and coverage details shown in these screenshots should be considered only as examples. Plans available through the marketplace will have Summary of Benefits and Coverage documents with real cost and coverage details.

Summary of Benefits and Coverage Highlights Key Plan Details

Under the Affordable Care Act, all health plans have to provide you with a standardized Summary of Benefits and Coverage. This document helps you understand what health services a plan covers and lets you compare coverage options across multiple plans.

General Plan Information

At the top of the Summary of Benefits and Coverage is a section with general details about the plan including the dates of coverage, the persons covered, and the type of plan. The Summary of Benefits and Coverage provides a link to a glossary of terms to help you better understand the summary. Note that this resource highlights key aspects of the plan but is not comprehensive. More details about the coverage will be available on the plan's website.



Coverage Period

If you enroll in a plan by December 15, 2013, coverage will begin January 1, 2014. During this first year, you have a bit of extra time to sign up for coverage—through March 30, 2014. After December 15, 2013, if you enroll between the 1st and the 15th of a month, coverage is effective on the first day of the next month. If you enroll between the 16th and final day of the month, coverage begins the first day of the second following month.

Who Is Covered

Plans will provide several options for who may be covered under the policy. You will be able to purchase coverage just for yourself (individual), for yourself and a spouse, or for yourself and family.

Plan Type

The plan type categorizes the plan based on how access to physicians and hospitals is structured. A Health Maintenance Organization (HMO) may require you to use only physicians in the plan's network. A preferred provider organization (PPO) may offer a broader choice of providers with different amounts of cost-sharing.

Important Questions	Answers
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific **deductibles**.
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
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.
Is there an overall annual limit on what the plan pays?	No.
Does this plan use a network of providers?	Yes. See **www.[insert].com or call 1-800-[insert]** for a list of participating providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.

Important Questions

Overall Plan Costs

The Summary of Benefits and Coverage lists important questions about your financial responsibility under the plan. This section of the document also answers "Why This Matters" and explains how the cost impacts you based on the care you select. For example, understanding your deductible is important because you must pay most of the costs of care up to the deductible amount before the plan begins to pay for covered services. In some cases, certain types of spending will not be subject to the deductible. In all cases, plans will cover preventive services before you reach the deductible. Some plans will have separate deductibles for certain health care costs, such as prescription medications. If most of your medical spending is concentrated in an area where there may be a separate deductible, choosing a plan that has a separate deductible for that service might lower your overall out-of-pocket costs. Otherwise, you may never reach the plan's overall deductible. Note that some plans will have separate out-of-pocket limits for network and non-network providers.

Access to Providers

Plans will provide information about their network of providers on the plan website or hotline. You may face higher costs to see providers who are out of your plan's network. You can use the information in this section to understand if the providers you see will be accessible under your plan and how much it will cost to see them.

Definitions

The Summary of Benefits and Coverage contains a list of definitions to help you understand commonly used terms in health insurance plans.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Covered Benefits and Costs

All health plans offered in the marketplace must cover a set of essential health benefits, including hospitalization, rehabilitation, and prescription medications. In addition, all health plans are required to offer a set of preventive services for free, such as checkups, immunizations, women's health services, and screening colonoscopies. Aside from these required benefits, each health plan offers different benefits, even if you are comparing insurance plans in the same metal level (for example, two silver plans could differ in how they cover certain services). This part of the Summary of Benefits and Coverage can help you determine if a service is covered and how much you will have to pay for it.

Common medical events are included in a set of charts with details about specific services, costs, and limits, when applicable. Examples of entries in these common medical event charts are detailed below.

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

Coverage for Prescription Medications

Coverage for prescription medications is one consideration for choosing your health plan. The set of medicines that a plan covers is called the plan's formulary. Formularies typically cover medications on different tiers. Each tier has an associated cost-sharing amount. Lower tiers usually have smaller out-of-pocket costs than higher tiers. Marketplace plans may have very high out-of-pocket costs associated with therapies covered on higher tiers. In addition, prescriptions may be subject to a plan's deductible either through an overall deductible or a separate deductible for prescriptions. The "Important Questions" section on the first page of the Summary of Benefits and Coverage document explains more details about the rules governing whether and how prescription drugs count towards the deductible.

The Summary of Benefits and Coverage provides a link to the plan's formulary. Make a list of the medicines you take and use the formulary to map each medication to the generic, preferred, non-preferred, and specialty categories. If prescription medications are a part of your ongoing health needs, repeat this process for all of the marketplace plans you are considering so that you don't face unforeseen difficulty accessing medications once you enroll.

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 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——————

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].

Coverage Examples

In addition, the Summary of Benefits and Coverage document provides you with examples of coverage for two specific medical events—managing type 2 diabetes and having a baby (normal delivery). In this guide, we show only the example on diabetes.

Each coverage example shows the total cost for the care and the breakdown between the plan and the patient costs.

The **Sample care costs** summary shows the details for each service that a person with this condition would receive over a year in the health plan. This section shows the breakdown of the total cost for the care by service received.

The **Patient pays** summary shows the individual's share of the total cost for the services that a person with this condition would receive over a year in the health plan. This section shows the breakdown of patient cost by amount spent for the deductible, copayments, coinsurance, and excluded benefits.

Excluded Services and Other Covered Services

The Summary of Benefits and Coverage lists services that are excluded from the plan you are considering. Make sure that you read the list of excluded services to be sure that you know what the plan will not cover. You should also make sure to check the plan document to be certain you review the complete list of excluded services.

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

The document also informs you if the plan covers special treatments such as acupuncture and weight loss programs. Be sure to review the full list of other covered services on the plan document.

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Most coverage provided outside the United States. See www.[insert]
- Weight loss programs

Provider Networks

It's important to understand which health care providers—such as physicians, pharmacies, and hospitals—are in the network of the plan you choose. Marketplace plans will have networks of providers (called "participating providers") from whom you can receive the most affordable care. These networks may include participating and non-participating providers. Participating providers will cost less out-of-pocket than non-participating providers.

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	

The marketplace website or Summary of Benefits and Coverage offers a link to each plan's network of providers. Review this listing of providers to determine if the physicians, facilities, and pharmacies you currently use are in-network with the plan you are considering.

Your Rights to Continue Coverage

The Summary of Benefits and Coverage provides information about your right to continue coverage from year to year. Your plan must offer you the chance to renew your policy *unless* you move out of the coverage area, fail to pay your premiums, or commit fraud. This rule prevents the insurance company from dropping your coverage because of the health services you use or if your health status changes. Your plan also will provide information on a grievances and appeals process so that you are able to file complaints if you feel you are wrongfully denied coverage for a service or medication.

Conclusion

The Summary of Benefits and Coverage guide is a tool to help you compare and contrast health plans. This resource will be available for all marketplace plans and is an important tool for helping you understand and select the best plan for you. You can find Summary of Benefits and Coverage documents for all insurance plans on the marketplace website or on each plan's own website.