What This Plan Covers and What it Costs
Instruction Guide for Group Coverage

Edition Date: February 2012

Purpose of the form: PHS Act section 2715 generally requires all group health plans and health insurance issuers offering group health insurance coverage to provide applicants, enrollees, and policyholders or certificate holders with an accurate summary of benefits and coverage.

General Instructions: Read all instructions carefully before completing the form.

- Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. Unless otherwise instructed, the plan or issuer must use 12-point (as required by Federal law) font, and replicate all symbols, formatting, bolding, and shading.
- Special Rule: To the extent a plan's terms that are required to be described in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible. Such situations may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program.
- Plans and issuers must customize all identifiable company information throughout the document, including websites and telephone numbers.
- The items shown on page 1 must always appear on page 1, and the rows of the chart must always appear in the same order. The chart starting on page 2 must always begin on page 2, and the rows shown in this chart must always appear in the same order. However, the chart rows shown on page 2 may extend to page 3 if space requires, and the chart rows on page 3 may extend to the beginning of page 4 if space requires. The *Excluded Services and Other Covered Services* section may appear on page 3 or page 4, but must always immediately follow the chart starting on page 2. The *Excluded Services and Other Covered Services* section must be followed by the *Your Rights to Continue Coverage* section, the *Your Grievance and Appeals Rights* section, and the *Coverage Examples* section, in that order.
- Footer: The footer must appear at the bottom left of every page. The plan or issuer must insert the appropriate telephone number and website information.

- For all form sections to be filled out by the plan or issuer (particularly in the *Answers* column on page 1, and the *Your Cost* and *Limitations & Exceptions* columns in the chart that starts on page 2), the plan or issuer should use plain language and present the information in a culturally and linguistically appropriate manner and utilize terminology understandable by the average individual. For more information, see paragraph (a)(5) of the Departments' final regulations.
- Plans and issuers with questions about completing the SBC may contact the Department of Health and Human Services at SBC@cms.hhs.gov or the Department of Labor at 866-444-EBSA(3272) or www.askebsa.dol.gov.

Filling out the form:

Top of page 1

Top Left Header (page 1):

On the top left hand corner of the first page, the plan or issuer must show the following information:

***First line*:** Show the plan name and name of plan sponsor and/or insurance company as applicable in 16 point font and bold. Example: "**Maximum Health Plan: Alpha Insurance Group**".

- Plans and issuers have the option to use their logo instead of typing in the company name if the logo includes the name of the entity sponsoring the plan or issuing the coverage.
- The plan or issuer must use the commonly known company name.

Top Right Header (page 1):

On the top right hand corner of the first page, the plan or issuer must show the following information:

***First line*:** After *Coverage Period*, the plan or issuer must show the beginning and end dates for the applicable coverage period (such as plan or policy year) in the following format: "MM/DD/YYYY – MM/DD/YYYY". For example: "Coverage Period: 01/01/2013 - 12/31/2013".

- If the coverage period end date is not known when the SBC is prepared, the plan or issuer is permitted to insert only the beginning date of the coverage period. For example: "Coverage Period: Beginning on or after 01/01/2013".
- If the SBC is being provided to satisfy the notice of material modification requirements, the plan or issuer must show the beginning and end dates for the period for which the modification is effective. For example, for a change effective March 15, 2013, and a plan year beginning on January 1, 2013 and ending on December 31, 2013: "Coverage Period: 03/15/2013 - 12/31/2013".

Second line:

- After *Coverage for*, indicate who the coverage is for (such as Individual, Individual + Spouse, Family). The plan or issuer should use the terms used in the policy or plan documents.
- After *Plan Type*, indicate the type of coverage, such as HMO, PPO, POS, Indemnity, or High-deductible.

Disclaimer (page 1):

The disclaimer at the top of page 1 should be replicated and the plan or issuer may not vary the font size, graphic, or formatting. The plan or issuer should insert a website and telephone number for accessing or requesting copies of the policy or plan documents. The plan or issuer should also include a website and telephone number for accessing or requesting copies of the Uniform Glossary. (Note: the Uniform Glossary can be accessed at: www.dol.gov/ebsa/healthreform and www.cciio.cms.gov. One or both of these Internet addresses may be used as a website designated for obtaining the Uniform Glossary.)

Important Questions/Answers/Why This Matters Chart

General Instructions for the *Important Questions* chart:

- This chart must always appear on page 1, and the rows must always appear in the same order. Plans and issuers must complete the *Answers* column for each question on this chart, using the instructions below.
- Plans and issuers must show the appropriate language in the *Why This Matters* box as instructed in the instructions below. Plans and issuers must replicate the language given for the *Why This Matters* box exactly, and may not alter the language.
- If there is a different amount for in-network and out-of-network expenses (such as annual deductible, additional deductibles, or out-of-pocket limits), list both amounts and indicate as such, using the terms to describe provider networks used by the plan or issuer. For example, if the plan uses the terms "preferred provider" and "non-preferred provider" and the annual deductible is $2,000 for a preferred provider and $5,000 for a non-preferred provider, then the *Answers* column should show "$2,000 preferred provider, $5,000 non-preferred provider".

1. *What Is The Overall Deductible?:*

***Answers* column:**

- If there is no overall deductible, answer "$0".
- If there is an overall deductible, answer with the dollar amount and, if the deductible is not annual, indicate the period of time that the deductible applies.

- If there is an overall deductible, underneath the dollar amount, plans and issuers must include language specifying major categories of covered services that are NOT subject to this deductible. For example, "Does not apply to preventive care and generic drugs".
- If there is an overall deductible, underneath the dollar amount plans and issuers must include language listing major exceptions, such as out-of-network co-insurance, deductibles for specific services and copayments, which do not count toward the deductible. For example, "Out-of-network co-insurance and copayments don't count toward the deductible."
- If portraying family coverage for which there is a separate deductible amount for each individual and the family, show both the individual deductible and the family deductible (for example, "$2,000 person / $3,000 family").

***Why This Matters* column:**

- If there is no overall deductible, show the following language: "See the chart starting on page 2 for your costs for services this plan covers."
- If there is an overall deductible, show the following language: "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**."

2. *Are There Other Deductibles for Specific Services?:*

***Answers* column:**

- If the overall deductible is the only deductible, answer with the phrase "No."
- If there are other deductibles, answer "Yes", then list the names and deductible amounts of the three most significant deductibles other than the overall deductible. Significance of deductibles is determined by the plan or issuer based on two factors: probability of use and financial impact on an individual. Examples of other deductibles include deductibles for Prescription Drugs and Hospital. For example: "Yes, $2,000 for prescription drug expenses and $2,000 for occupational therapy services".
- If the plan has more than three other deductibles and not all deductibles are shown, the following statement must appear at the end of the list: "There are other specific **deductibles**."
- If the plan has less than three other deductibles, the following statement must appear at the end of the list: "There are no other specific **deductibles**."
- If portraying family coverage for which there is a separate deductible amount for each individual and the family, show both the individual and family deductible. For example: "Prescription drugs -- Individual $200, Family $500"

***Why This Matters* column:**

- If there are no other deductibles, the plan or issuer must show the following language: "You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers."
- If there are other deductibles, the plan or issuer must show the following language: "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."

3. *Is There An Out-of-Pocket Limit On My Expenses?:*

***Answers* column:**

- If there are no out-of-pocket limits, respond "No."
- If there is an out-of-pocket limit, respond "Yes", along with a specific dollar amount that applies in each coverage period. For example: "Yes. $5,000".
- If portraying family coverage, and there is a single out-of-pocket limit for each individual and a separate out-of-pocket limit for the family, show both the individual out-of-pocket limit and the family out-of-pocket limit (for example, "Individual $1,000 / Family $3,000").
- If there are separate out-of-pocket limits for in-network providers and out-of-network providers, show both the in-network out-of-pocket limit and the out-of-network out-of-pocket limit. Plans and issuers should use the terminology in the policy or plan document (e.g., in-network, participating, or preferred). For example: "For participating providers $2,500 person/$5,000 family; For non-participating providers $4,000 person/$8,000 family"

***Why This Matters* column:**

- If there is an out-of-pocket limit, the plan or issuer must show the following language: "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."
- If there is no out-of-pocket limit, the plan or issuer must show the following language: "There's no limit on how much you could pay during a coverage period for your share of the cost of covered services."

4. *What Is Not Included In The Out-of-Pocket Limit?:*

***Answers* column:**

- If there is no out-of-pocket limit, indicate "This plan has no **out-of-pocket limit**."
- If there is an out-of-pocket limit, the plan or issuer must list any major exceptions. This list must always include the following three terms: premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover. Depending on the plan, the list could also include: copayments, out-of-network co-insurance, deductibles, and penalties for failure to obtain pre-authorization for services. The plan or issuer must state that these items do not count toward the limit. For example: "Copayments, premiums, balance-billed charges, and health care this plan doesn't cover."

***Why This Matters* column:**

- If there is an out-of-pocket limit, the plan or issuer must show the following language: "Even though you pay these expenses, they don't count toward the **out–of–pocket limit**."
- If there is no out-of-pocket limit, the issuer must show "Not applicable because there's no **out-of-pocket limit** on your expenses."

5. *Is There An Overall Annual Limit On What The Plan Pays?:*

***Answers* column:**

- The plan or issuer should respond "Yes" or "No" based on whether the plan has an overall annual limit.
- If the answer is "Yes", the plan or issuer should include a brief description and dollar amount of the overall annual limit. For example: "Yes, $2 million."
- If the plan does not have an overall annual limit, the plan or issuer should state, "No."

***Why This Matters* column:**

- If there is an overall annual limit, the plan or issuer must show the following language: "This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits."
- If there is no overall annual limit, the plan or issuer must show the following language: "The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits."

6. *Does This Plan Use A Network of Providers?:*

***Answers* column:**

- If this plan does not use a network, the plan or issuer must respond, "No."
- If the plan does use a network, the plan or issuer must respond, "Yes," and include information on where to find a list of preferred providers or in-network providers, etc. For example: "Yes. For a list of **preferred providers**, see www.[insert].com or call 1-800-[insert]." Plans and issuers should use the terminology in the policy or plan document (e.g., in-network, participating, or preferred).

***Why This Matters* column:**

- If this plan uses a network, the plan or issuer must show the following language: "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**."

- If this plan does not use a network, the plan or issuer must show the following language: "This plan treats **providers** the same in determining payment for the same services."

7. *Do I Need A Referral To See A Specialist?:*

***Answers* column:**

- Plans and issuers should use plan specific language with respect to specialists. For example, distinguishing between preferred and non-preferred specialists or in-network and out-of-network specialists.
- Plans and issuers should specify whether written or oral approval is required to see a specialist.
- Plans and issuers should specify whether specialist approval is different for different plan benefits.

***Why This Matters* column:**

- If there is a referral required, the plan or issuer must show the following language: "This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**"
- If there is no referral required, the plan or issuer must show the following language: "You can see the **specialist** you choose without permission from this plan".

8. *Are there services this plan doesn't cover?:*

***Answers* column:**

- If there are any items or services the plan doesn't cover the plan or issuer should answer "Yes". (A "No" answer should be inserted only if the plan covers all items and services without any exclusions or limitations, including any limitations based on medical necessity.)

***Why This Matters* column:**

- If there are no excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the plan or issuer must show the language: "See your policy or plan document for information about **excluded services**."
- If there are excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the plan or issuer must show the language: "Some of the services this plan doesn't cover are listed on page [3 or 4]. See your policy or plan document for additional information about **excluded services**." The plan or issuer should insert the correct page (3 or 4) depending on where the *Services Your Plan Does Not Cover* box appears on the form.

Common Medical Event, Services, Cost Sharing, Limitations & Exceptions

Cost Sharing Information Box:

- The first three bullets in the information box at the top of page 2 should be replicated with the same text, formatting, graphic, bolded words, and bullet points. Only the fourth bullet may change.
- The fourth bullet will change depending on the plan:
    - For plans that use a network, the plan or issuer should fill in the blank on the fourth bullet of the template, using the terminology that the plan or issuer uses for "in-network" or "preferred provider". This should be the same term as used in the heading of the first sub-column under the *Your Cost* column.
    - For non-networked plans, the plan or issuer should delete the fourth bullet and replace it with: "Your cost sharing does not depend on whether a provider is in a network."

Chart Starting on page 2:

Location of Chart:

This chart must always begin on page 2, and the rows shown on pages 2 and 3 must always appear in the same order. However, the rows shown on page 2 may extend to page 3 if space requires, and the rows shown on page 3 may extend to the beginning of page 4 if space requires. The heading of the chart must appear on the top of all pages used.

***Your Cost* columns:**

- Plans and issuers may vary the number of columns depending upon the type of coverage and the number of preferred provider networks. Most plans or issuers that use a network should use two columns, although some plans or issuers with more than one level of in-network provider may use three columns. Non-networked plans may use one column.
- Plans and issuers should insert the terminology used in the policy or plan document to title the columns. For example, the columns may be called "In-network" and "Out-of-network", or "Preferred Provider" and "Non-Preferred Provider" based on the terms used in the policy. (Plans and issuers should be aware that consumer testing has demonstrated that consumers more readily understand the terms "In-network" and "Out-of-network".) The sub-headings should be deleted for non-networked plans with only one column.
- The columns should appear from left to right, from most generous cost sharing to least generous cost sharing. For example, if a 3-column format is used, the columns might be labeled (from left to right) "In-Network Preferred Provider," "In-Network Provider," and then "Out-of-Network Provider."

- For HMOs providing no out-of-network benefits, the plan or issuer should insert "Not covered" in all applicable boxes under the far-right sub-heading under the *Your Cost* column (which, for coverage providing out-of-network benefits, would usually be out-of-network provider or non-preferred provider column).
- Plans and issuers must complete the responses under these sub-headings based on how the plan or issuer covers the specific services listed in the chart. Fill in the *Your Cost* column(s) with the co-insurance percentage, the co-payment amount, "No charge" if the employee pays nothing, or "Not covered" if the service is not covered by the plan. When referring to co-insurance, include a percentage valuation. For example: 20% co-insurance. When referring to co-payments, include a per occurrence cost. For example: $20/visit or $15/prescription.
- Refer to the specific additional instructions below for details on completing the *Your Costs* columns in the chart for the following common medical events:
    - If you visit a health care provider's office or clinic;
    - If you need drugs to treat your illness or condition; and
    - If you have mental health, behavioral health, or substance abuse needs.

***Limitations & Exceptions* column:**

In this column, list the significant limitations and exceptions for each row. Significance of limitations and exceptions is determined by the plan or issuer based on two factors: probability of use and financial impact on an individual. Examples include, but are not limited to, limits on the number of visits, limits on specific dollar amount paid by the plan, prior authorization requirements, unusual exceptions to cost sharing, lack of applicability of a deductible, or a separate deductible.

- Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."
- If the plan or issuer requires the participant or beneficiary to pay 100% of a service in-network, then that should be considered an "excluded service" and should appear in the *Limitations & Exceptions* column and also appear in the *Services Your Plan Does Not Cover* box on page 3 or 4. For example, coverage that excludes services in-network such as habilitation services, prescription drugs, or mental health services, must show these exclusions in both the *Limitations & Exceptions* column and the *Services Your Plan Does Not Cover* box.
- If there are pre-authorization requirements, the plan or issuer must show the requirement including specific information about the penalty for noncompliance.
- If there are no items that need to appear in the *Limitations & Exceptions* box for a row, then the plan or issuer should show "---none---".
- For each *Common Medical Event* in the chart, the plan or issuer has the discretion to merge the boxes in the *Limitations & Exceptions* column and display

one response across multiple rows if such a merger would lessen the need to replicate comments and would save space.

- Refer to the specific additional instructions below for details on completing the *Limitations & Exceptions* column in the chart for the following common medical events:
    - If you have outpatient surgery; and
    - If you have a hospital stay.

Specific Additional Instructions for Some of the *Common Medical Events:*

If you visit a health care provider's office or clinic:

- If the plan or issuer covers other practitioners care (which includes chiropractic care and/or acupuncture), in the "Other practitioner office visit" row, the issuer will provide the cost sharing for the other practitioners care in the *Your Cost* columns. For example, under the in-network column, the issuer may respond "20% co-insurance for chiropractor and 10% co-insurance for acupuncture".
- If the plan or issuer does not cover other practitioners care, the issuer will show "Not Covered" in the *Your Cost* columns for *Other Practitioner Office visit*.

If you need drugs to treat your illness or condition:

- Under the *Common Medical Events* column, provide a link to the website location where the participant or beneficiary can find more information about prescription drug coverage for this plan. If there is no website, provide a contact phone number where the participant or beneficiary can receive more information about prescription drug coverage for this plan.
- Under the *Services You May Need* column, the plan or issuer should list and complete the categories of prescription drug coverage under the plan (for example, the issuer might fill out 4 rows with the terms, "Generic drugs", "Preferred brand drugs", "Non-preferred brand drugs", and "Specialty drugs"). It is recommended that plans and issuers avoid the term "tiers" and instead use "categories" as it is more easily understood by consumers.
- Under the *Your Cost* column, plans and issuers should include the cost sharing for both retail and mail order, as applicable.

If you have outpatient surgery:

- If there are significant expenses associated with a typical outpatient surgery that have higher cost sharing than the facility fee or physician/surgeon fee, or are not covered, then they must be shown under the *Limitations & Exceptions* column. Significance of such expenses is determined by the plan or issuer based on two factors: probability of use and financial impact on the participant or beneficiary. For example, a plan or issuer might show that the cost sharing for the physician/surgeon fee row is "20% co-insurance", but the *Limitations & Exceptions* might show "Radiology 50% co-insurance".

If you have a hospital stay:

- If there are significant expenses associated with a typical hospital stay that has higher cost sharing than the facility fee or physician/surgeon fee, or are not covered, then that must be shown under the *Limitations & Exceptions* column. Significance of such expenses is determined by the plan or issuer based on two factors: probability of use and financial impact on the participant or beneficiary. For example, a plan or issuer might show that the cost sharing for the facility fee row is "20% co-insurance", but the *Limitations & Exceptions* might show "Anesthesia 50% co-insurance".

If you have mental health, behavioral health, or substance abuse needs:

- If the cost sharing differs for outpatient services for mental/behavioral health needs or substance abuse needs depending on whether the services are office visits or are other outpatient services, show the cost sharing for each. For example, a plan or issuer might show that the cost sharing for Mental/Behavioral health outpatient services is "$35 co-pay/visit for office visits and 20% co-insurance other outpatient services".

Disclosures

The *Excluded Services and Other Covered Services*, *Your Rights to Continue Coverage, Your Grievance and Appeals Rights,* and *Coverage Examples* sections must always appear in the order shown. The *Excluded Services and Other Covered Benefits* section may appear on page 3 or page 4 depending on the length of the chart starting on page 2, but it will always follow immediately after the chart starting on page 2.

Excluded Services and Other Covered Services:

- Each plan or issuer must place all services listed below in either the *Services Your Plan Does Not Cover* box or the *Other Covered Services* box according to the plan provisions. The required list of services includes:
    - Acupuncture,
    - Bariatric surgery,
    - Chiropractic care,
    - Cosmetic surgery,
    - Dental care (Adult),
    - Hearing aids,
    - Infertility treatment,
    - Long-term care,
    - Non-emergency care when traveling outside the U.S.,
    - Private-duty nursing,
    - Routine eye care (Adult),
    - Routine foot care, and
    - Weight loss programs.
- The plan or issuer may not add any other benefits to the *Other Covered Services* box other than the ones listed above. However, other benefits may be added to the *Services Your Plan Does Not Cover* box, as follows:
    - If services appear in the *Limitations & Exceptions* column in the chart starting on page 2 because the plan or issuer requires the participant or beneficiary to pay 100% of the service in-network, those services should also appear in the *Services Your Plan Does Not Cover* box.

- For example, coverage that excludes services in-network, such as habilitation services, prescription drugs, or mental health services, must show these exclusions in both the *Limitations & Exceptions* column (in the chart starting on page 2) and in the *Services Your Plan Does Not Cover* box.

- List placement must be in alphabetical order for each box. The lists must use bullets next to each item.
- In lieu of summarizing coverage for items and services provided outside the United States, the plan or issuer may provide an internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. This statement should appear in the *Other Covered Services* box. For example: "Coverage provided outside the United States. See www.[insert].com/expatriate"
- If the plan or issuer provides limited coverage for any of the services listed above, the limitation must be stated in the *Services Your Plan Does Not Cover* box or the *Other Benefits Covered* box but not both. For example if a plan provides acupuncture in limited circumstances, the plan or issuer could choose to include the prescribed statement in the *Services Your Plan Does Not Cover* box, as follows: "Acupuncture unless it is prescribed by a physician for rehabilitation purposes." Alternatively, the prescribed statement could be in the *Other Covered Services* box, as follows: "Acupuncture if it is prescribed by a physician for rehabilitation purposes."
- For example, if a plan or issuer excludes all of the services on the list above except Chiropractic services, and also showed exclusion of Habilitation Services on page 2, the *Other Covered Services* box would show "Chiropractic Care" and the *Services Your Plan Does Not Cover* box would show "Acupuncture, Bariatric Surgery, Cosmetic surgery, Dental care (Adult), Habilitation Services, Hearing Aids, Infertility treatment, Long-term care, Non-emergency care when travelling outside the U.S., Private-duty nursing, Routine eye care (Adult), Routine foot care, Weight loss programs."

Your Rights to Continue Coverage:

The following language must appear without alteration, as follows:

"If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov."

Your Grievance and Appeals Rights:

This section must appear.

Contact information should be inserted as follows (more than one of these instructions may be applicable):

- For group health coverage subject to ERISA, insert applicable plan contact information. Also insert contact information for the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If coverage is insured, also insert applicable State Department of Insurance contact information.
- For non-federal governmental group health plans and church plans that are group health plans, insert contact information for member assistance provided by any TPA or issuer that is hired by or contracts with the plan, and, if available, consumer assistance offered directly by the plan such as applicable member services, employee services, Human Relations or Fiscal and Personnel Department, or consumer support services. If coverage is insured, also insert applicable State Department of Insurance contact information.
- If applicable in your state insert: "Additionally, a consumer assistance program can help you file your appeal. Contact [insert contact information]." A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/prgrams/consumer/capgrants/index.html.

Coverage Examples

- The U.S. Department of Health and Human Services (HHS) will provide all plans and issuers with standardized data to be inserted in the *Sample care costs* section for the coverage examples. HHS will also provide underlying detail that will allow plans and issuers to calculate *Patient pays* amounts, including: Date of Service, medical coding information, Provider Type, Category, descriptive Notes identifying the specific service provided, and Allowed Amounts.
- The *Amount owed to providers*, also known as the Allowed Amount, will always equal the Total of the *Sample care costs*. Each plan or issuer must calculate cost sharing, using the detailed data provided by HHS, and populate the *Patient pays* fields. Dollar values are to be rounded off to the nearest hundred dollars (for sample care costs that are equal to or greater than $100) or to the nearest ten dollars (for sample care costs that are less than $100), in order to reinforce to consumers that numbers in the examples are estimates and do not reflect their actual medical costs. For example, if the co-insurance amount is estimated at $57, the issuer would list $60 in the appropriate *Patient pays* section of the Coverage Examples.
- Services on the template provided by HHS are listed individually for classification and pricing purposes to facilitate the population of the *Patient pays* section. HHS

specifies the Category used to roll up detail costs into the *Sample care costs* categories section. Some plans may classify that service under another category and should reflect that difference accordingly. The plan or issuer should apply their cost sharing and benefit features for each plan in order to complete the *Patient pays* section, but must leave the *Sample care costs* section as is. Examples of categories that might differ between the *Patient pays* and *Sample care costs* sections could include, but are not limited to:

  - Payment of services based on the location where they are provided (inpatient, outpatient, office, etc.)
  - Payment of items as prescription drugs vs. medical equipment

- Each plan or issuer must calculate and populate the *Patient pays* total and sub-totals based upon the cost sharing and benefit features of the plan for which the document is being created. These calculations should be made using the order in which the services were provided (Date of Service).

  - **Deductible** – includes everything the participant or beneficiary pays up to the deductible amount. Any co-pays that accumulate toward the deductible are accounted for in this cost sharing category, rather than under co-pays.
  - **Co-pays** – those co-pays that don't apply to the deductible.
  - **Co-insurance** – anything the participant or beneficiary pays above the deductible that's not a co-pay or non-covered service. This should be the same figure as the Total less the Deductible, Co-Pays and Limits or exclusions.
  - **Limits or exclusions** – anything the participant or beneficiary pays for non-covered services or services that exceed plan limits.

- Each plan or issuer must calculate and populate the *Plan pays* amount by subtracting the *Patient pays* total from the *Amount owed to providers* total.

- If the plan has a wellness program that varies the deductibles, co-payments, co-insurance, or coverage for any of the services listed in a treatment scenario, the plan must complete the calculations for that treatment scenario assuming that the patient is participating in the wellness program. Additionally, the plan must also include a box below the coverage example with the following language (and appropriate contact information):

  - For Pregnancy:

    Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: [insert].

  - For Diabetes:

    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].

- If all of the costs associated with the Coverage Examples are excluded under the plan, then the phrase "(This condition is not covered, so patient pays 100%)" is added after the *Patient pays* amount. Otherwise no narrative should appear after the *Patient pays* amount.
- Plans and issuers must include the *Questions and answers about the Coverage Examples* section as it appears and not alter the text, font, graphic, shading, etc. This section should be placed immediately following the Coverage Examples.