What Your Plan Covers and What it Costs

Draft Instruction Guide for Individually Purchased or Non-Group Policies

Edition Date: July 2011

Purpose of the form: Beginning in March 2012, the Patient Protection and Affordable Care Act (PPACA) requires all health insurance issuers offering individual health insurance coverage to provide enrollees and potential enrollees an accurate summary of benefits and coverage explanation. This form does not apply to excepted benefits as defined by the Public Health Services Act (PHSA). Federal law requires this document so consumers will find it easier to compare policies and understand their coverage.

Requirements to provide the form: As set forth below, this form must be provided to an applicant, to the policyholder or to the certificate holder at the time of issuance of the policy or delivery of the certificate and to the policyholder or certificate holder at renewal, as applicable.

While it is the insurer's, or a representative of the insurer's, responsibility to accurately fill out and deliver the form, these instructions acknowledge that consumers receive information about their health insurance through three primary channels of communication: 1) insurance companies, 2) agents, and 3) solicitations made via telemarketers and the internet. The following are the permitted methods of delivery:

a. When an insurer, or a representative of an insurer, meets in person with the potential applicant, the insurer or a representative of the insurer may hand-deliver the completed form to the individual. Alternatively, the insurer, or representative of the insurer, may offer the individual the following options, and shall provide the form to be delivered in the manner selected by the individual:
    1) A printed copy deposited in the United States mail, postage pre-paid, within seven (7) days of the request;
    2) An electronic copy delivered to an e-mail address provided by the individual;
    3) An electronic copy delivered via a link on the Internet;
    4) A copy delivered by any other means acceptable to both the insurer and the individual.

b. For an applicant who conducts the insurance application electronically, the insurer, or a representative of the insurer, must make the form available on the electronic site and the insurer must require the applicant to acknowledge receipt of the form as a necessary step to completing the initial application process.

c. For an insurance application that is completed over the phone or through the mail, the insurer, or a representative of the insurer, shall offer a printed copy of the completed form

within seven (7) days to the address provided by the applicant. Alternatively, the insurer, or representative of the insurer, may offer the individual the following options, and shall provide the form to be delivered in the manner selected by the individual:

1) An electronic copy delivered to an e-mail address provided by the individual;
2) An electronic copy delivered via a link on the Internet;
3) A copy delivered by any other means acceptable to both the insurer and the individual.

d. When an insurer issues a policy or delivers a certificate the form shall be included with the policy or certificate and provided in the manner selected by the policy holder or certificate holder.

e. When the policy or certificate is renewed, the insurer shall provide the form in the same manner in which the policy or certificate were provided along with the renewal documents.

An oral description of the form is not sufficient. An insurer, or a representative of the insurer, may not provide the form solely by orally explaining the form and its contents either in person or over the telephone.

If two or more applicants jointly request an insurance product or service from an insurer, the insurer may satisfy the requirement to provide this form by providing one form to those applicants jointly.

Unless otherwise required by law, this form is a freestanding document and may not be incorporated into any other document that an insurer, or an insurer's representative, provides to an applicant, policy holder or certificate holder.

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

- This form must be filled out accurately and by the insurer in good faith.
- Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. Unless otherwise instructed, the insurer must use 12-point (as required by federal law) Times New Roman font, and replicate all symbols, formatting, bolding, colors, and shading exactly. Attached is an example of a blank form.
- Insurers must customize all identifiable company information throughout the document, including websites and telephone numbers.
- 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 insurer. For example, if the policy 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 Answer column should show "$2000 preferred provider, $5,000 non-preferred provider".
- 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 shown in the example must always begin on Page 2, and the rows shown on 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 insurer must insert the appropriate telephone number and website information.
- For all form sections to be filled out by the insurer (particularly in the *Answers* column on page 1, and the *Your Cost* and *Limitations and Exceptions* columns in the chart that starts on page 2), the insurer should use plain language and present the information in a culturally and linguistically appropriate manner and utilize terminology understandable by the average individual.

Filling out the form:

Top Left Header (Page 1):

On the top left hand corner of the first page, the insurer must show the following information:

- **First line:** Show the plan name and insurance company name in 16 point font and bold. Example: "**Maximum Health Plan: Alpha Insurance Group**".
    - o Insurers have the option to use their logo instead of the typing in the company name if the logo includes the name of the entity issuing the coverage.
    - o The insurer must use the commonly known company name.

Top Right Header (Page 1):

On the top right hand corner of the first page, the insurer must show the following information:

- **First line:** After *Policy Period*, the insurer must show the beginning and end dates for the applicable policy period in the following format: "MM/DD/YYYY – MM/DD/YYYY". For example: "Policy Period: 09/15/2010 - 09/14/2011".
- **Second line**:
    - o After the words "Coverage For", indicate who the policy is for (such as Individual, Individual + Spouse, Family). The insurer will use the terms used by the policy, but should ensure that the term used will make it easy for the consumer to compare similar types of plans.
    - o After the words "Plan Type", indicate the type of insurance plan, such as HMO, PPO, POS, Indemnity, or High-deductible.

Disclaimer (Page 1):

The disclaimer should be replicated and the insurer may not vary the font size, graphic or formatting. The insurer should insert the plan's website and telephone number.

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. Insurers must complete the *Answers* column for each question on this chart, using the instructions below.
- Insurers must show the appropriate language in the *Why This Matters* box as instructed in the instructions below. Insurers must replicate the language given for the *Why This Matters* box exactly, and may not alter the language.
- When responding with a list of items, use words such as "and", "or", or "plus" rather than using a semi-colon. For example: "Yes, $5,000 deductible for prescription drugs and $2,000 for occupational therapy" rather than "Yes, $5,000 for prescription drugs; $2,000 for occupational therapy".

1. *What Is The Premium?*:

Answers column:

a. Answer with the dollar amount (rounded to the closest whole dollar) and time period (such as monthly). Example: "$[xxx] [monthly]".

b. Premium amounts may be provided in good faith by the insurer or agent.

c. If a consumer is shopping for plans and has yet to fill out a health insurance application or has not yet been medically underwritten, insurers may, consistent with state law, use a base premium based on five factors: the number of people to be covered by the policy (i.e. individual or family), age, gender, smoking status, and location (zip code).

Why This Matters column:

d. The insurer must always insert the following language: "The **premium** is the amount paid for health insurance."

e. If the consumer is shopping for plans and has been provided a base premium as described in (c) above, the insurer must also include the statement: "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". This sentence should appear immediately after the sentence described in (d) above.

2. *What Is The Overall Deductible?*:

Answers column:

a. If there is no calendar year or policy period deductible, answer "$0".

b. If there is a calendar year or policy period deductible, answer with the dollar amount and indicate whether it is based on a calendar year, or policy period. For example: "$5,000 for calendar year" or "$5,000 for policy period".

c. If there is a calendar year or policy period deductible, underneath the dollar amount insurers 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".

d. If there is a calendar year or policy period deductible, underneath the dollar amount insurers must include language listing major exceptions, such as out-of-

network coinsurance, deductibles for specific services and copayments, which do not count toward the deductible. For example, "Out-of-network coinsurance and copayments don't count toward the deductible."

e. Show the answer for the type of policy only. For example, if this is an individual policy, show answers only for individual. If a family policy and there is a single deductible amount for the family, show answers only for family.

f. If portraying a family policy for which there is a separate deductible amount for each individual and the family, show the individual deductible on the first line, and the family deductible on the second line. For example, the first line may show "Individual $2,000" and the second line may show "Family $3,000".

Why This Matters column:

g. If there is no calendar year or policy period deductible, show the following language: "See the chart starting on page 2 for your other costs for services this plan covers."

h. If there is a calendar year or policy period deductible, show the following language: "You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy 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**."

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

Answers column:

a. If the calendar year or policy period deductible is the only deductible, answer with the phrase "No, there are no other deductibles." Do not answer with just one word.

b. If there are other deductibles, answer "Yes", then list the names and deductible amounts of the three most significant deductibles other than the annual deductible. Significance of deductibles are determined by the insurer based on two factors: probability of use and financial impact on the consumer. Examples of other deductibles include deductibles for Prescription Drug, Hospital, and Mental Health). For example: "Yes, $2,000 for prescription drug expenses and $2,000 for occupational therapy services".

c. 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 deductibles."

d. If the plan has less than three other deductibles, the following statement must appear at the end of the list: "There are no other deductibles."

e. Show the answer for the type of policy only. For example, if this is an individual policy, show answers only for individual. If this is a family policy and there is a single deductible amount for the family, show answers only for family.

f. If portraying a family policy 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:

g. If there are no other deductibles, the insurer must show the following language: "Because you don't have to meet **deductibles** for specific services, this plan starts to cover costs sooner."

h. If there are other deductibles, the insurer must show the following language: "You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services."

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

Answers column

a. If there are no out-of-pocket limits, respond "No. There's no out-of-pocket limit on your expenses" on the first line. Do not respond with a one-word answer.

b. If there is an out-of-pocket limit, respond "Yes", along with a specific dollar amount that applies in each plan year, and to each charge with a separate out-of-pocket limit on the first line. For example: "Yes. $5,000".

c. If there are other types of annual limits, such as annual or plan year limits on visits, services or drugs, then the insurer must show the following language on the second line: "Other limits apply – see the chart that starts on Page 2".

d. If an individual policy, show answers only for individual. If a family policy and there is a single out-of-pocket limit for the family, show answers only for family.

e. If portraying a family policy, for which there is a single out-of-pocket limit for each individual and a separate out-of-pocket limit for the family, show the individual out-of-pocket limit on the first line, and the family out-of-pocket limit on the second line. For example, the first line may show "Individual $1,000" and the second line may show "Family $3,000".

Why This Matters column:

f. If there is an out-of-pocket limit, the insurer must show the following language: "The **out-of-pocket** limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses."

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

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

Answers column

a. If there is no out-of-pocket limit, indicate "This question doesn't apply to this plan."

b. If there is an out-of-pocket limit, the insurer must list any major exceptions. This list must always include: premium, balance-billed charges, and health care this plan doesn't cover. Depending on the policy, the list could also include: copayments, out of network coinsurance, deductibles, and penalties for failure to obtain pre-authorization for services. The insurer must state that these items do not count toward the limit. For example: "Copayments, premium, balance-billed charges, and health care this plan doesn't cover."

Why This Matters column:

c. If there is an out-of-pocket limit, the insurer must show the following language: "Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage."

d. If there is no out-of-pocket limit, the insurer must show "Not applicable because there's no **out-of-pocket limit** on your expenses".

6. ***Is There An Overall Annual Limit On What The Insurer Pays?***

Answers column

a. The insurer should respond "*Yes*" or "*No*" based on whether the policy has an overall annual limit.

b. If the answer is "Yes", the insurer should include a brief description and dollar amount of the overall annual limit. For example: "Yes. This policy has an overall annual limit of $750,000".

c. If the answer is "No", the insurer should state, "No. This policy has no overall annual limit on the amount it will pay each year."

Why This Matters column:

d. If there is an overall annual limit, the insurer must show the following language: "This plan will pay for covered services only up to this limit during each policy 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."

e. If there is no overall annual limit, the insurer must show the following language: "The chart starting on page 2 describes any limits on what the insurer will pay for *specific* covered services, such as office visits."

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

Answers column

a. If this plan does not use a network, the insurer must respond, "No. This plan doesn't use a network". Do not use a one-word response.

b. If the plan does use a network, the insurer must briefly explain its network policy. For example "Yes, this plan uses preferred providers. You may use health care providers that aren't preferred providers, but you may pay more."

c. Insurers have the ability to use plan specific language when distinguishing between preferred provider and non-preferred provider or in-network and out-of-network out-of-pocket limits, etc.

d. Include information on where to find a list of preferred providers or in-network providers, etc. For example "For a list of preferred providers, see www.insurancecompany.com or call 1-888-123-4567."

e. ER and other exceptions to non-preferred provider requirements should add that information to answer field.

f. Plans should highlight that some out-of-network specialists are often used by network providers (e.g., anesthesiologists).

Why This Matters column:

g. If this plan uses a network, the insurer 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. Plans use the terms **in-network**, **preferred**, or **participating** to refer to providers in their network."

h. If this plan does not use a network, the insurer must show the following language: "The providers you choose won't affect your costs."

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

Answers column:

a. Insurers have the ability to use plan specific language when distinguishing between preferred provider and non-preferred specialists or in-network and out-of-network out-of-pocket limits, etc.

b. Insurers should specify whether a written or verbal approval is required to see a specialist.

c. Insurers should specify whether specialist approval is different for different plan benefits.

Why This Matters column:

d. If there is a referral required, the insurer 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."

e. If there is no referral required, the insurer must show the following language: "You can see the **specialist** you choose without permission from this plan".

9. ***Are There Services This Plan Doesn't Cover?:***

Answers column:

a. If there are any items in the *Services Your Plan Does Not Cover* box on page 3 or 4, the insurer should answer "Yes". See the instructions for the *Excluded Services and Other Covered Services* section for more related information.

Why This Matters column:

b. If there are no excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the insurer must show the language: "This plan also covers many common health care services listed on page [3 or 4]." The insurer should note the correct page (3 or 4) depending on where the *Services Your Plan Does Not Cover* box appears on the form.

c. If there are excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the insurer must show the language: "Some of the services this plan doesn't cover are listed on page [3 or 4]." The insurer should insert the correct page (3 or 4) depending on where the *Services Your Plan Does Not Cover* box appears on the form.

Covered Services, Cost Sharing, Limitations and Exceptions

Information Box:

- 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 most plans that use a network, the insurer should fill in the blank on the 4th bullet, using the terminology that the insurer uses for "in-network" or "preferred

provider". This should be the same term as used in the heading of the far-left sub-column under the *Your Cost* column.

  - For plans that have the same cost-sharing percentage for in-network services as out-of-network services, the insurer should delete the 4th bullet and replace it with: "Your costs for [in-network] providers will be lower than [out-of-network] providers." Insert the term used for in-network providers and out-of-network providers shown on the sub-column headers under the *Your Costs* column.
  - For non-networked plans, the insurer should delete the 4th bullet and replace it with: "Your costs are the same no matter which provider you see."

- If any of the explanations in this box are inaccurate for the plan, then the insurer should use the chart (in either the *Your Cost* column or the *Limitations and Exceptions* column) below to show that information. For instance, if cost-sharing is not subject to the deductible (and therefore the second bullet is not accurate for this plan), then the insurer should indicate in the *Your Cost* column next to each cost-sharing charge that the charge is "not subject to the deductible".

Chart starting on page 2:

1. **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 all pages used.

2. ***Your Cost* columns:**
   a. Insurers may vary the number of sub-columns depending upon the type of policy and the number of preferred provider networks. Most policies that use a network should use two columns, although some policies with more than one level of in-network provider may use three columns. HMOs should use two columns. Non-networked plans may use one column.
   b. Insurers should insert the terminology used in the policy to title the sub-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. Insurers 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.
   c. The columns should appear from left to right, from most in-network to most out-of-network. For example, if a 3-column format is used, the sub-columns might be labeled (from left to right) "In-Network Preferred Provider," "In-Network Provider", and then "Out-of-Network Provider."
   d. For HMOs providing no out-of-network benefits, the insurer should insert "Not covered" in all applicable boxes under the far-right sub-heading under the Your Cost column (which, for policies providing out-of-network benefits, would usually be out-of-network provider or non-preferred provider column.

e. Insurers must complete the responses under these sub-columns based on how the health insurance coverage covers the specific services listed in the chart.

1) Fill in the costs column(s) with the co-insurance percentage, the co-payment amount, "No charge" if the consumer pays nothing, or "Not covered" if the service is not covered by the plan. When referring to coinsurance, include a percentage valuation. For example: 20% coinsurance. When referring to co-payments, include a per occurrence cost. For example: $20/visit or $15/prescription.

2) When responding with a list of items, use words such as "and", "or", or "plus" rather than using a semi-colon. For example: "Yes, $5,000 deductible for prescription drugs and $2,000 for occupational therapy" rather than "Yes, $5,000 for prescription drugs; $2,000 for occupational therapy".

3. *Limitations and Exceptions* Column:

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

b. The limitation and 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."

c. If the policy requires the consumer to pay 100% of a service in-network, then that should be considered an "excluded service" and should appear in the *Limitations and Exceptions* column and also appear in the *Services Your Plan Does Not Cover* box on Page 3 or 4. For example, policies that exclude services in-network such as pregnancy, habilitation services, prescription drugs, or mental health services, must show these exclusions in both the *Limitations and Exceptions* column and the *Services Your Plan Does Not Cover* box.

d. If there are pre-authorization requirements, the insurer must show the requirement including specific information about the penalty for non-compliance.

e. If there are no items that need to appear in the limitations and exceptions box for a row, then the insurer should show "----none---".

f. For each section of the chart (for each *Common Medical Event*), the insurer has the discretion to merge the boxes in the *Limitations and Exceptions* column and display one response across multiple rows if such a merger would lessen the need to replicate comments and would save space.

4. Specific Instructions for *Common Medical Events:*

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

1) If the policy covers other practitioners care (which includes chiropractic care and/or acupuncture), in the "Other practitioner office visit" row, the insurer will provide the cost-sharing for the other practitioners care in the *Your Cost* columns. For example, under the in-network sub-column, the insurer may respond "20% coinsurance for chiropractor and 10% coinsurance for acupuncture".

2) If the policy does not cover other practitioners care, the insurer will show "Not Covered" in the Your Cost columns for *Other Practitioner Office visit*.

b. *If you need drugs to treat your illness or condition:*

1) Under the *Common Medical Events* column, provide a link to the website location where the consumer can find more information about prescription drug coverage for this policy.

2) Under the *Services You May Need* column, the insurer should list and complete the categories of prescription drug coverage in the policy (for example, the insurer might fill out 4 rows with the terms, "Generic drugs", "Preferred brand drugs", "Non-preferred brand drugs", and "Specialty drugs". It is recommended that insurers avoid the term "tiers" and instead use "categories" as it is more easily understood by consumers.

3) Under the *Your cost* column, insurers should include the cost-sharing for both retail and mail-order.

c. *If you have outpatient surgery:*

1) 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 and Exceptions* column. Significance of such expenses are determined by the insurer based on two factors: probability of use and financial impact on the consumer. For example, an insurer might show that the cost-sharing for the physician/surgeon fee row is "20% coinsurance", but the *Limitations and Exceptions* might show "Radiology 50% coinsurance".

d. If you have a hospital stay:

1) 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 in under the *Limitations and Exceptions* column. Significance of such expenses are determined by the insurer based on two factors: probability of use and financial impact on the consumer. For example, an insurer might show that the cost-sharing for the facility fee row is "20% coinsurance", but the *Limitations and Exceptions* might show "anesthesia 50% coinsurance".

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:

1. Each insurer 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 policy provisions. The required list of services includes: Acupuncture, Bariatric Surgery, Non-emergency care when travelling outside the U.S., Chiropractic Care, Cosmetic Surgery, Dental care (adult), Hearing aids, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, and Weight loss programs.

2. The insurer may not add any other benefits to the *Other Covered Services* box other than the ones listed in (1) above.

3. Services that appear in the *Limitations and Exceptions* column in the chart starting on page 2 because the policy requires the consumer to pay 100% of the service in-network, should also appear in the *Services Your Plan Does Not Cover* box. For example, policies that exclude services in-network such as pregnancy, habilitation services, prescription drugs, or mental health services, must show these exclusions in both the *Limitations and Exceptions* column (in the chart starting on page 2) and in this *Services Your Plan Does Not Cover* box.

4. List placement must be in alphabetical order for each box. The lists must use bullets next to each item.

5. For example, if an insurer excludes all of the services on the list above (#1) except Chiropractic services, and also showed exclusion of Habilitation Services on Page 2 and exclusion of Dental care (child) on page 3, the Other Benefits Covered box would show "Chiropractic Care" and the *Services Your Plan Does Not Cover* box would show "Acupuncture, Non-emergency care when travelling outside the U.S., Cosmetic surgery, Dental care (child), Habilitation Services, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, Routine hearing tests, Weight loss programs."

6. If the insurer provides limited coverage for one of the services listed in (1) above, the limitation must be stated in the *Services Your Plan Does Not Cover* box or the Other Benefits Covered box. For example if an insurer provides acupuncture in limited circumstances, the statement in the *Services Your Plan Does Not Cover* box would show: Acupuncture unless it is prescribed by a physician for rehabilitation purposes, Non-emergency care when travelling outside the U.S., Cosmetic surgery, Dental care (adult),

Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, Routine hearing tests, Weight loss programs."

Your Rights to Continue Coverage:
This section must appear. Insurers must include the following items:

- "you commit fraud or intentional misrepresentations of material fact",
- "the insurer stops offering this policy or services in the state"
- "you move outside the coverage area"

Insurers must also include the following for association plans:

- "your employer/sponsor changes insurance carrier"

***Your Grievance and Appeals Rights*:**
This section must appear. Depending on where plans are sold, identify the proper state health insurance customer assistance program and include their website and phone number.

***Coverage Examples*:**

a. HHS will provide all insurers with standardized data to be inserted in the "Sample care costs" section for each coverage example. HHS will also provide underlying detail that will allow carriers to calculate "You Pay" amounts, payments including: Date of Service, CPT code, Provider Type, Category, descriptive Notes identifying the specific service provided, and Allowed Amount.

b. The "Amount owed to providers," also known as the Allowed Amount, will always equal the Total of the "Sample care costs." Each insurer must calculate cost sharing, using the detailed data provided by HHS, and populate the "You Pay" 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 coinsurance amount is estimated at $57, the insurer would list $60 in the appropriate "You Pay" section of the Coverage Example.

c. Services on the template provided by HHS are listed individually for classification and pricing purposes to facilitate the population of the "You Pay" section. HHS specifies the Category used to roll up detail costs into the "Sample care cost" categories section. Some plans may classify that service under another category and should reflect that difference accordingly. The insurer should apply their cost sharing and benefit features for each policy in order to complete the "You pay" section, but must leave the "Sample care costs" section as is. Examples of categories that might differ between the You Pay 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

d. Each insurer must calculate and populate the "You pay" 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).

   1. **Deductible** – includes everything the member 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

   2. **Co-pays** – those co-pays that don't apply to the deductible

   3. **Limits or exclusions** – anything member pays for non-covered services or services that exceed plan limits.

   4. **Co-insurance** – anything member 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.

e. Each insurer must calculate and populate the "Plan pays" amount by subtracting the "You pay" total from the "Amount owed to providers" total.

f. If all of the costs associated with the "having a baby" example are excluded under the plan, then the phrase "(maternity is not covered, so you pay 100%)" is added after the "You pay" amount. Otherwise no narrative should appear after the "You pay" amount.

g. Insurers must use the "Questions and answers about Coverage Examples" as they appear and not alter the text, font, graphic, shading or colors [Should insurers be allowed to print in black and white?]. This should be placed immediately following the Coverage Examples.

h. If the insurer provides coverage only for medical services (e.g., pharmacy or mental health benefits are carved out and administered by another insurer), the insurer should complete the Coverage Example for only those benefits that it covers, consistent with the features outlined on pages 1 to 4 of the Summary of Coverage. These non-covered costs for excluded services would show up under the "limits and exclusions" section of the "You Pay" table. [NOTE: Should we require inclusion of a disclaimer on the Coverage Example (and on the Summary of Coverage) that notes that certain benefits may be administered by a separate insurer? Should we also amend the instructions for the Summary of Coverage to address this issue in terms of how the benefits are described?]

Need Assistance?

Insurers should contact __________________ at _________________ to obtain assistance in completing these documents.