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

Edition Date: December 2014 (proposed)

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 (SBC).

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

- Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. The plan or issuer must use 12-point font, and replicate all symbols, formatting, bolding, and shading where applicable. Plans and issuers are encouraged to use the font types Arial and Garamond when reproducing the SBC template, which consumer focus groups found to be easy to read. (Arial font type in the headers, section titles, chart row titles and coverage examples, where applicable. Garamond font type for the remaining substantive text in the body of the document.) However, there may be situations where the use of Arial and Garamond would distort the layout of certain sections or cause the SBC to run over 8 pages. In such cases, it may be more appropriate for plans and issuers to utilize other font types to reproduce an SBC in a manner that is consistent with the SBC template format.
- 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 (health FSA) or a health reimbursement arrangement (HRA), or if a plan provides different cost sharing based on participation in a wellness program. Additional examples of flexibility available under this Special Rule include:
    - In the event a State requirement prohibits or requires the use of certain terminology that is inconsistent with the terminology in the SBC template or instruction guide, the issuer may modify the template or instruction terminology to be consistent with the State requirement. For example if a State requires the use of the term "spinal manipulation" instead of the term "chiropractic care", the issuer may modify this term in the template.

- Plans and issuers may combine information for different coverage tiers in one SBC, provided the appearance is understandable. In such circumstances, the coverage examples should be completed using the cost sharing (for example, deductible and out-of-pocket limits) for the self-only coverage tier (also sometimes referred to as the individual coverage tier). In addition, the coverage examples should note this assumption.
- If the participant is able to select the levels of deductibles, copayments, and coinsurance for a particular benefit package, plans and issuers may combine information for different cost-sharing selections (such as levels of deductibles, copayments, and coinsurance) in one SBC, provided the appearance is understandable. This information can be presented in the form of options, such as deductible options and out-of-pocket maximum options. In these circumstances, the coverage examples should note the assumptions used in creating them. An example of how to note assumptions used in creating coverage examples is provided in the Departments' sample completed SBC.
- Plans and issuers may combine information for add-ons to major medical coverage that could affect cost sharing (such as a health FSA, HRA, health savings account (HSA), or wellness program) and other information in the SBC, in one SBC if the information is understandable. That is, the effects of such add-ons can be denoted in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. In such circumstances, the coverage examples should note the assumptions used in creating them.

- Plans and issuers may collapse the two lines under “If you are pregnant” in the Common Medical Event charts if the plan uses the global maternity CPT code.
- Plans and issuers must customize all identifiable company information throughout the document, including websites and telephone numbers.
- Minor adjustments are permitted to row or column size in order to accommodate the plan’s information, as long as information is understandable. However, deletion of columns or rows is not permitted unless otherwise noted in these instructions. Additionally, rolling over information from one page to another is permitted.
- The items shown on page 1 must begin on page 1, and the rows of the chart must appear in the same order. However, the chart starting on page 2 may begin on page 2 or in the alternative may be moved to the bottom of page 1 if space allows the first box to appear in its entirety. The rows shown in this chart must appear in the same order. Further, the rows shown on page 2 may extend to page 3 if space requires, and the rows on page 3 may extend to the beginning of page 4 if space requires. The *Excluded Services and Other Covered Services* section must immediately follow the chart that starts 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, the *Individual Responsibility* section, the language access information (if applicable), and the *Coverage Examples* section, in that order.

- 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' regulations.
- The SBC is not permitted to substitute a cross-reference to the SPD or other documents for any content element of the SBC. However, an SBC may include a reference to the SPD in the box at the top of the first page of the SBC. (For example, "Questions: Call 1-800-[insert] or visit us at www.[insert].com for more information, including a copy of your plan's summary plan description.") In addition, wherever an SBC provides information that fully satisfies a particular content element of the SBC, it may add to that information a reference to specified pages or portions of the SPD in order to supplement or elaborate on that information.
- Barcodes, control numbers, or other similar language may be added to SBCs by plans or issuers for quality control purposes.
- A plan or issuer may choose to add premium information to the SBC. If the plan or issuer voluntarily adds the premium information, it should be added at the end of the SBC form immediately before the Your Rights to Continue Coverage section.
- 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 and Bottom of page 1

Header: The header may be included only on the first page of SBC.

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 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.
- Additional space may be used to add employer/group name if needed.

- The header may roll onto a third line if all required information cannot fit into two lines.
- The plan or issuer must use the commonly known company name.
- Plan names may be generic, such as standard or high option. Additionally, issuer name and plan name are interchangeable in order.

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: 01/01/2016 - 12/31/2016".

- 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 01/01/2016".
- 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, 2016, and a plan year beginning on January 1, 2016 and ending on December 31, 2016: "Coverage Period: 03/15/2016 - 12/31/2016".
- The dates listed for the coverage period may reflect the coverage period for the plan or policy as a whole, not the period applicable to each individual. Therefore, if a plan is a calendar year plan and an individual enrolls on January 19, the coverage period is permitted to be the calendar year. Plans and issuers are not required to individualize the coverage period for each individual's enrollment.
- If a plan has a plan year that differs from the benefit year; for example the plan year begins Oct. 1, but the benefits (e.g. deductibles and out-of-pocket limits) reset on Jan. 1; the plan may choose, based on a determination of what is most relevant to the consumer, to reflect the coverage period as either the plan year or the benefit year.

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 exactly, without changes to the font size, graphic, or formatting. The plan or issuer should insert contact information (such as telephone number and/or website) for obtaining more detail or a copy of the complete terms of coverage. Issuers must also include a website where consumers can review and obtain copies of the group certificate of coverage. Finally, the plan or issuer must include a website and telephone number for accessing or requesting copies of the Uniform Glossary. (One or both of the following Internet addresses may be used as a website designated for obtaining the Uniform Glossary: www.dol.gov/ebsa/healthreform or www.cciio.cms.gov.)

Important Questions/Answers/Why This Matters Chart

General Instructions for the *Important Questions* chart:

- This chart must always begin 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 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**."

- 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 or $3,000/family”).

Why This Matters **column:**

- If there is no overall deductible, show the following language: “See the Common Medical Events chart below 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 1). The Common Medical Events chart below shows 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 coverage** 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 -- $200/person or $500/family”

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.”
- 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, “$1,000/person or $3,000/family”).
- 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 or $5,000/family; For non-participating **providers** $4,000/person or $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 on certain services, out-of-network coinsurance, 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** on certain services, **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. *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. See www.[insert].com or call 1-800-[insert] for a list of participating **providers**." 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 health care **provider**, this **plan** will pay some or all of the costs of covered services. Lesser coverage, or no coverage, may be available for out-of-network **providers**. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services (such as lab work). "
- 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."

6. *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**".

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

Common Medical Event Chart Starting on page 2:

Location of Chart:

This chart should begin on page 2 (or at the bottom of page 1, if space allows) and the rows shown on pages 2 and 3 must 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.
- The columns are intended to reflect the consumer costs after the deductible has been satisfied.
- Plans and issuers should denote in these columns exceptions, such as when a specific service is subject to a separate deductible or is covered at no cost.
- 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 after the deductible has been satisfied. Fill in the *Your Cost* column(s) with the coinsurance percentage, the copayment amount, "No charge" if the employee 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 percent coinsurance. When referring to copayments, 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 the 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 percent 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 following the chart. 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 imposed on a covered individual for noncompliance. (If the penalty only applies to the provider and not to the covered individual, the penalty for noncompliance is not required to be included.)
- 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.

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 percent coinsurance/chiropractor; 10 percent coinsurance/acupuncture".

- While the instructions and the template explicitly list chiropractic care and acupuncture as other practitioners care, this row can also be used to reference office visits to nurses, physician assistants, and any other practitioner office visit that is not a primary care office visit or specialist office visit.

- 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 space allows (i.e., the 8-page limit would not be exceeded), plans and issuers may include information on additional types of practitioners, such as a nurse practitioners or physician assistants.

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 percent coinsurance", but the *Limitations & Exceptions* might show "50 percent coinsurance/radiology".

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 percent coinsurance", but the *Limitations & Exceptions* might show "50% coinsurance/anesthesia".

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 copayment/office visit and 20% coinsurance/other outpatient services".

Disclosures

The *Excluded Services and Other Covered Services*, *Your Rights to Continue Coverage, Your Grievance and Appeals Rights,* Individual Responsibility, Language Access (if applicable), and *Coverage Examples* sections must always appear in the order shown. The *Excluded Services and Other Covered Benefits* must always follow immediately after the chart that starts 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 percent of the service in-network, those services must 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."
- 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:

This section must appear as shown on the template. Insert contact information for the plan or issuer in the second sentence. In the second sentence,

- For group health coverage subject to ERISA, 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.
- For non-federal governmental group health plans, insert contact information for the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Your Grievance and Appeals Rights:

This section must appear as shown on the template. 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://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Individual Responsibility:

This section must appear.

For employer-provided group health plans that provide minimum value, insert:

> **Does this Coverage Satisfy the Individual Responsibility Requirement and Meet the Minimum Value Standard?**
> Yes. This coverage constitutes **minimum essential coverage** under the Affordable Care Act, so enrolling in this coverage satisfies your obligations under the **individual responsibility requirement**. In addition, this coverage provides a level of benefits specified in the Affordable Care Act as "minimum value."

For employer-provided group health plans that do not provide minimum value, insert:

> **Does this Coverage Satisfy the Individual Responsibility Requirement?**
> Yes. This coverage constitutes **minimum essential coverage** under the Affordable Care Act, so enrolling in this coverage satisfies your obligations under the **individual responsibility requirement**.
>
> **Does this Coverage Provide "Minimum Value"?**
> No. This coverage does not provide the level of benefits specified in the Affordable Care Act as "minimum value." As a result, you may be

eligible for financial assistance to help you afford coverage purchased through a **Marketplace** if you decide not to enroll in this plan.

Language Access Services, taglines, culturally and linguistically appropriate requirements (if applicable):

- In order to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules in the claims and appeals regulations under PHS Act section 2719. Plans and issuers can find written translations of the SBC template and uniform glossary in non-English languages at http://cciio.cms.gov/programs/consumer/summaryandglossary/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.
    - All plans and issuers will be allowed continued use of the Coverage Examples Calculator. For the calculator, instructions, and logic, see http://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Summary of Benefits and Coverage and Uniform Glossary.
- 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 generally 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 issuer would list $60 in the appropriate *Patient pays* section of the Coverage Examples.
    - If applying the rounding rules causes the deductible amount displayed to exceed the actual overall deductible (for self-only coverage), then the deductible amount must be capped and shown as the amount of the actual deductible. For example, if the overall deductible is $1,750 and will be satisfied, then the plan or issuer must show “$1,750” and not $1,800.”

- 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 copayments that accumulate toward the deductible are accounted for in this cost sharing category, rather than under copayments.
    - **Copayment** – those copayments that don't apply to the deductible.
    - **Coinsurance** – anything the participant or beneficiary pays above the deductible that's not a copayment or non-covered service. This should be the same figure as the Total less the Deductible, Copayments 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, copayments, coinsurance, 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, if applicable, 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 the plan's 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].

- For Simple Fracture/ ER Visit:

  Note: These numbers assume the patient receives emergency care in an in-network facility from in-network providers. If you do not receive care from an in-network provider, your costs may be higher. For more information, 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 percent)" is added after the *Patient pays* amount. Otherwise no narrative should appear after the *Patient pays* amount.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately one minute per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

OMB Control Number 1545-2229, 1210-0147, and 0938-1146 [expires (proposal)]