National Association of Insurance Commissioners & The Center for Insurance Policy and Research

October 14, 2015

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Thomas E. Perez
Secretary
U.S. Department of Labor
200 Constitution Ave., N.W.
Washington, D.C. 20210

The Honorable Jacob J. Lew
Secretary
U.S. Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Secretaries Burwell, Perez and Lew:

Thank you for the opportunity to submit to the Department of Health and Human Services, Department of Labor, and Department of the Treasury (collectively the "Tri-Agencies") recommendations on the Summary of Benefits and Coverage (SBC) and Uniform Glossary as revised in the proposed regulations from Dec. 30, 2014. (79 Fed. Reg. 249, 78578), which includes a new set of proposed SBC templates, instructions, and an updated uniform glossary. We write as the chief insurance regulators of our respective states and members of the National Association of Insurance Commissioners (NAIC).

Similar to the work performed with the original SBC and Uniform Glossary[1], the NAIC convened the Consumer Information (B) Subgroup (Subgroup) comprised of regulators and an advisory working group of consumer representatives, industry representatives and provider groups. The Subgroup held conference calls open to the public starting April 20, 2015 twice-weekly. Calls were initially an hour, moved to 90 minutes in May and were extended to two hours in July. Additionally, and perhaps most importantly, the work product underwent consumer testing. The NAIC hired Kleimann Communication Group, LLC to conduct cognitive interview consumer testing. Testing was conducted in Baltimore, Maryland, and Kansas City, Missouri, in September. Angela Nelson (Chair of the Subgroup) and Mary Mealer from the Missouri Department of Insurance observed the testing in Kansas City. NAIC staff observed the testing in Baltimore. The final testing report is available on the NAIC website at http://www.naic.org/committees_b_consumer_information.htm. The Subgroup revised the SBC in response to feedback received from consumer testing, which is detailed for your information in the attached Memorandum.

[1] Pursuant to §1001 of the Patient Protection and Affordable Care Act (ACA) (adding § 2715 to the Public Health Service Act) the NAIC convened a working group comprised of state regulators and a diverse group of stakeholders to develop a summary of benefits and coverage document and uniform glossary. This working group met in open conference calls and in-person meetings that were open to the public to develop the original summary of benefits and coverage templates, instructions and uniform glossary. See www.naic.org/committees_b_consumer_information.htm.

Provided are our recommendations, which include a recommended SBC template, coverage examples, and instructions for group plans and individual plans and issuers to populate the SBC. Also attached is an explanatory memorandum for your reference detailing the changes we made to the template along with the rationale. The Subgroup intends to revise the Uniform Glossary as well, which we were unable to complete in time to include with this recommendation. Because the Uniform Glossary does not require customization by plans and issuers, we trust that transmitting our Glossary recommendations to you before the end of the year gives all parties sufficient time to use the Uniform Glossary in 2017. Although our revisions to the Uniform Glossary are not complete, notes to the Tri-Agencies referencing the Uniform Glossary have been included in the instructions where we thought it was appropriate to alert you.

Note that our recommended SBC Template is less than 4 pages double-sided, as required by the Section 2715 of the Patient Protection and Affordable Care Act (ACA). We interpret the statutory page limitation as applying to the "uniform format" and not to the SBC after it has been completed. All stakeholders participating in our process agreed that any other interpretation of the 4 page limit is inconsistent with the stated purpose of the SBC and would severely and unnecessarily restrict the amount and quality of information provided to consumers.

With the initial implementation of the ACA, the Tri-Agencies worked with employers, issuers, states, providers and other stakeholders to help them come into compliance. Guidance issued on May 11, 2012 through FAQs[2] indicates "Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law." We know and appreciate the significant number of issuers and plans will be impacted by these recommended changes and believe these groups will make good faith efforts to understand and implement these revisions by January 1, 2017. However, due to the complexity of programming or amending various systems and business practices, we strongly encourage the same approach as was provided by the Tri-Agencies in 2012.

As we developed these documents, several issues came to our attention that we believe the Tri-Agencies should consider:

- The Uniform Glossary – During Consumer testing it became clear that the glossary greatly increased consumers' understanding of the SBC. To that end, we think it is critical for consumers to be able to readily get to definitions of terms they don't understand. For those with an electronic SBC, this means being able to link electronically to definitions. We recommend that the Tri-Agencies embed links to definitions within the underlined glossary terms in the SBC Template. Each underlined term should link directly to a specific definition within the glossary, or at a minimum to a glossary page. If possible, hover technology that has the definition appear when a person places their cursor over an underlined term in the SBC would be best. We think this investment in technology would be a huge benefit to consumers. Along these same lines, the Tri-Agencies have multiple glossaries online with inconsistent definitions. These definitions need to be aligned and, ideally, consolidated; although direct link technology within the SBC Template could go a long ways towards alleviating any potential confusion to consumers who encounter a different glossary and/or definition on a government website. We also encourage the Departments to consider ways to ensure use of the uniform glossary through navigators, agents and brokers as a valuable tool to aid in understanding key terms.

- Additional plan detail – While the NAIC and the Subgroup believe the appropriate interpretation of the page limitation applies to the uniform template, concerns still remain regarding the volume of

[2] See, http://www.dol.gov/ebsa/faqs/faq-aca.html

information presented in a completed SBC form. Consumer testing revealed there is a saturation point for consumers in terms of the amount of technical insurance information they can absorb and more importantly, comprehend and apply. When text boxes are long and full of complex terms, consumers will avoid reading the information in its entirety. All regulators reviewing completed SBC forms must avoid the temptation to add more information simply because there is no page limitation. The NAIC has received very sage advice from its consumer representatives over the years which is "more information is not necessarily better for insurance consumers".

- Self-funded plans – State Insurance Departments have long encountered situations where consumers with self-funded health plans never realize that they have self-funded plans because they are administered by insurance companies. While state insurance departments assist consumers in self-funded plans as much as they can, ERISA preempts state laws as applied to self-funded plans. The Tri-Agencies should require disclosure of self-funded status somewhere on the SBC, possibly in the header.

- Tri-Agency Guidance – The NAIC is aware of the extensive body of guidance from the Tri-Agencies to assist all affected parties in complying with the ACA. These efforts are appreciated and result in helpful guidance, but occasionally the guidance extends beyond interpretive guidance into the realm of regulatory requirements. State Insurance Regulators remain concerned about guidance that goes beyond interpreting the statute and believes that affirmative regulatory obligations need to go through the rulemaking process allowing for notice and comment.

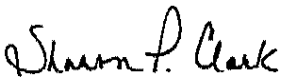
- Future revisions to the SBC – The NAIC and the Subgroup strongly believe the revisions to the SBC template will directly and significantly benefits consumers. However, as with all consumer documents, the SBC is a living document that should be revised periodically to address consumers' needs. The NAIC is willing and would strongly encourage the Tri-Agencies to consult with it regarding any future revisions to the SBC. The NAIC can facilitate a thoughtful and open discussion regarding changes from all interested stakeholders. The NAIC would gladly collaborate with the Tri-Agencies prior to any referral to ensure adequate time is set aside to undertake a comprehensive review.

We remain ready and willing to provide any additional assistance or review regarding these documents. Please contact us with any questions.

Sincerely,

Monica J. Lindeen
NAIC President
Commissioner
Montana Office of the Commissioner of Securities and Insurance, State Auditor

John M. Huff
NAIC President-Elect
Director
Missouri Department of Insurance, Financial Institutions and Professional Registration



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Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

For definitions of underlined terms in this document, see the Glossary at www.[HHSmicrosite].com or call 1-8[xx]-[xxx-xxxx] for a copy.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows how you and the plan would share the cost for covered health care services. NOTE: The SBC doesn't include the monthly cost of this plan (called the premium). You'll get that information separately.

The SBC has 4 parts:

- "**COVERAGE OVERVIEW**" gives you basic information about your share of the costs (cost sharing) for health care services covered under this plan. You'll learn how much you'll have to pay out of your pocket before this plan starts to pay (the deductible) and how much you'll have to pay before the plan covers the rest of the costs (the out-of-pocket limit).

- "**COMMON MEDICAL EVENTS**" will give you information about your cost sharing for health care services under this plan for certain types of health services. The most common types of health care services are listed.

  You'll see the difference in your cost sharing when you use a network provider (one who contracts with the plan to provide services at a discount). If you don't use a network provider, your cost sharing will be higher – and, you might have to pay the difference between what the plan pays and what that provider bills (balance billing).

- "**GENERAL INFORMATION**" gives you a list of some of the other health care services this plan covers and some it doesn't. You'll see information about where to call if you have problems with your plan after you buy it. You'll also learn if this plan meets two standards (Minimum Essential Coverage and Minimum Value), and how to get information in other languages.

- The last part, "**COVERAGE EXAMPLES**", shows how the deductibles, copayments and coinsurance work in this plan for three different medical events. The costs of medical services shown in these three examples aren't real. Your cost of medical care would be different.

This document is only a summary. For more information about this plan, or to get a copy of the plan documents, contact the plan at 1-8[xx]-[xxx-xxxx] or www.[insertwebsite].com.

Next: COVERAGE OVERVIEW

COVERAGE OVERVIEW		
Important Questions	**Answers**	**Why This Matters:**
What is the overall deductible?		
Are there services covered before you meet your deductible?		
Are there other deductibles for specific services?		
What is the out-of-pocket limit for this plan?		
What is not included in the out-of-pocket limit?		
Will you pay less if you use a network provider?		
Do you need a referral to see a specialist?		

Next: COMMON MEDICAL EVENTS

[All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.] ***REMEMBER***, definitions of underlined terms can be found in the Glossary at: [www.HHSmicrosite.gov].

COMMON MEDICAL EVENTS CHART				
Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions and Other Important Information**
		["Network Provider"] (You will pay the least)	**["Out-of-Network Provider"] (You will pay the most)**	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness			
	Specialist visit			
	Preventive care/screening/ immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Advanced Imaging (CT/PET scans, MRIs)			
If you need prescription drugs to treat your illness or condition	For more information about prescription drug coverage, what drugs are covered and your cost, see: www.[insert].com.			
	[Insert Tier Name] (*You will pay less of the cost*)			
	[Insert Tier Name] (*You will pay more of the cost*)			
	[Insert Tier Name] (*You will pay even more of the cost*)			
	[Insert Specialty Drug Tier Name] (*Additional higher cost options*)			

Common Medical Events continue on next page

COMMON MEDICAL EVENTS CHART, continued				
Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions and Other Important Information**
		["Network Provider"] (You will pay the least)	**["Out-of-Network Provider"] (You will pay the most)**	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care			
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fees			
If you need mental health, behavioral health or substance abuse services	Outpatient services			
	Inpatient services			
If you are pregnant	Office visits			
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Events continue on next page

COMMON MEDICAL EVENTS CHART, continued				
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		["Network Provider"] (You will pay the least)	["Out-of-Network Provider"] (You will pay the most)	
If you need help recovering or have other special health needs	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice services			
If your child needs dental or eye care	Children's eye exam			
	Children's glasses			
	Children's dental check-up			

Next: GENERAL INFORMATION

GENERAL INFORMATION ABOUT THIS PLAN

Excluded Services (Services Your Plan Does NOT Cover)

This chart lists some services that may be excluded under this plan. Check your plan for a complete list of excluded services.

Other Covered Services

This chart lists some covered services in addition to those listed in the Common Medical Events Chart. Check your plan for other covered services and your costs.

YOUR RIGHTS: GRIEVANCES, APPEALS and CONTINUATION OF COVERAGE

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. There are also agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

[Contact Information]	[Complaints, Grievances, Appeals, External Review, Continuation of Coverage]
[Healthcare.gov www.HealthCare.gov or call 1-800-318-2596][state health insurance marketplace or SHOP]	Other coverage options

MINIMUM ESSENTIAL COVERAGE/MINIMUM VALUE STANDARD

Does this plan provide Minimum Essential Coverage? **[Yes/No].** If you don't have Minimum Essential Coverage, you'll have to pay a penalty unless you get an exemption from the requirement to have health coverage.	Does this plan meet the Minimum Value Standard? **[Yes/No].** [Variable answer depending on the market]

LANGUAGE ACCESS SERVICES

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** [company phone #].

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [company phone #].

Spanish (Español): Para obtener asistencia en Español, llame al [company phone #].

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [company phone #].

Next: **COVERAGE EXAMPLES**

Coverage Examples: Understanding How This Plan Works

Below shows how this plan works in three different medical events. The "Total Example Costs" used below aren't real. Your cost of medical care will be different. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services. Use this information to compare what you might pay under different health plans.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible:** $
- **Specialist copayment:** $
- **Hospital (Facility) copayment:** $
- **Coinsurance:** %

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$

In this EXAMPLE, Peg would pay:

Cost Sharing:	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered:	
Excluded services	$
The total Peg would pay is:	**$**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible:** $
- **Physician copayment:** $
- **Prescription Drug copayment:** $
- **Coinsurance:** %

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$

In this EXAMPLE, Joe would pay:

Cost Sharing:	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered:	
Excluded services	$
The total Joe would pay is:	**$**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible:** $
- **Emergency room copayment:** $
- **Rehabilitation copayment:** $
- **Coinsurance:** %

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$

In this EXAMPLE, Mia would pay:

Cost Sharing:	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered:	
Excluded services	$
The total Mia would pay is:	**$**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Summary of Benefits and Coverage:
What this Plan Covers & What You Pay for Covered Services
Instruction Guide for Group Health Coverage

Edition Date: FINAL 10/06/15

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).

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

A. Form language and formatting must be 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 charts or sections to begin or end abruptly. 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, avoiding too much empty space within sections and the beginning of another.

B. Special Rule: To the extent a health benefit 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 health benefit 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.

1. Such situations may occur, for example, if a health benefit plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a health benefit plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan or issuer is denoting the effects of a related health flexible spending arrangement (health FSA) or a health reimbursement arrangement (HRA), or if a health benefit plan provides different cost sharing based on participation in a wellness program. If participation in a wellness program or other arrangement is optional, the *Answers* column in the Coverage Overview and the "*You will pay…*" column(s) in the Common Medical Events chart, and the Coverage Examples, should always reflect the basic health benefit plan for comparison purposes. Plans and issuers may choose to note the impact of other optional features, such as wellness programs, on cost sharing amounts in the *Limits, Exclusions and Other Important Information* column in the Common Medical Events chart.

2. Additional examples of flexibility available under this Special Rule include:

   a. Plans and issuers may combine information for different coverage tiers in one SBC, provided the appearance is understandable.

b. If the participant is able to select different coverage levels (i.e., self-only vs. family) with associated different 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. For example, on the Coverage Overview page, in the Answers column related to deductible, information entered could look like this: "$2,000 individual / $4,000 family." 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.

c. Plans and issuers may not modify information in the *You will pay…* column(s) to reflect impact of add-ons to major medical coverage that could affect cost sharing (such as a health FSA, HRA, health savings account (HSA), or wellness program). Information about add-ons can be noted in the *Limits, Exclusions and Other Important Information* column in the Common Medical Events chart.

d. Plans and issuers may collapse the two lines under "If you are pregnant" in the Common Medical Event charts if the health benefit plan uses the global maternity CPT code.

C. Plans and issuers must customize all identifiable company information throughout the document, including websites and telephone numbers.

D. Minor adjustments are permitted to row or column size or margins in order to accommodate the health benefit 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.

E. This document has 4 Parts: (1) *Coverage Overview,* (2) *Common Medical Events,* (3) *General Information,* and (4) *Coverage Examples.* Plans and issuers must start each section on a new page, in order, with the title at the top. Sections may continue onto subsequent pages, with the title indicating it is a continuation at the top. The bottom of each page must indicate what section comes next, for example, "Coverage Overview continued on next page" or "Next: Common Medical Events", as appropriate.

F. For all form sections to be filled out by the plan or issuer (particularly in the *Answers* column in Part (1) *Coverage Overview*, and the *Limitations, Exceptions and Other Important Information* column in Part (2) *Common Medical Events*), 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. A plan or issuer may make slight modifications to any required language to be inserted within the SBC if such slight modification is reasonably designed to ensure accuracy or to improve readability due to policy language.

G. The SBC is not permitted to substitute a cross-reference to the SPD or other

documents for any content element of the SBC.

H. Barcodes, control numbers, or other similar language may be added to SBCs by plans or issuers for quality control purposes. Page numbers may be relocated along the bottom of pages to accommodate barcodes, control numbers or other similar language.

I. With respect to these SBC instructions, the Office of Personnel Management (OPM) may provide additional instructions for Multi-State Plan issuers.

J. 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) www.askebsa.dol.gov.

K. Terms that are defined in the Glossary should be underlined in the SBC. Plans and issuers providing an electronic SBC should make sure defined terms hyperlink directly to the Glossary, ideally directly to the definition in the Glossary for that term.

Note to Tri-Agencies: ***The subgroup recommends that you develop a static microsite as a single click source for the glossary.*** ***Neither of the websites in the NPRM are specific and require consumers to hunt for the document they actually want. This eliminates any need for issuers to customize this piece of the SBC and will be beneficial over time as consumers learn there is one gold standard location for this document. Additionally, technology embedded into the SBC that allows consumers to put the cursor over a glossary term and see the definition without going to a separate website would be best.***

II. Header and footer information: Top and Bottom of page 1

A. Header: The header must be included on the first page of the SBC, but may also be included on other subsequent pages of the SBC at the option of the plan or issuer.

B. Top Left Header (page 1):

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

   a. First line: Show the health benefit plan name and name of plan sponsor and/or insurance company as applicable in bold. Example: “Maximum Health Plan: Alpha Insurance Group.”

   b. 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

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

   d. The header may roll onto a third line if all required information cannot fit into two lines.

   e. The plan or issuer must use the commonly known company name.

f. Health benefit plan names may be generic, such as standard or high option. Additionally, the issuer's name and the health benefit plan name are interchangeable in order.

C. Top Right Header (page 1):

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

a. *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."

b. 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."

c. 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."

d. The dates listed for the coverage period may reflect the coverage period for the health benefit plan as a whole, not the period applicable to each individual. Therefore, if a health benefit 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.

e. If a health benefit 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 sponsor for self-funded health benefit plans and the issuer for fully insured health benefit plans may choose to reflect the coverage period as either the plan year or the benefit year.

2. Second line on the right:

a. After *Coverage for:* indicate who the coverage is for (such as Individual, Individual + Spouse, Family).

b. The plan or issuer should use the terms used in the policy or plan documents.

c. After *Plan Type:* indicate the type of coverage, such as HMO, PPO, POS, Indemnity, or High-deductible.

D. Title - centered at the top of Page 1:

1. Plans and issuers must include the title "Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services"

E. Disclaimer - bottom of Page 1:

1. The disclaimer at the bottom of page 1 should be replicated exactly, without changes to the font size, graphic, or formatting.

2. In the fully insured market, the issuer should insert the following phrase: “For more information about this plan, or to get a copy of the plan documents, contact the plan [insert toll-free phone number] or [insert website]. Self-funded plans should insert the following phrase: “For more information about this plan, contact [insert telephone number, email, website or other appropriate contact information].” Issuers in a merged market (combining individual and group markets) should refer to the Individual Instructions.

III. COVERAGE OVERVIEW on Page 2:

A. General Instructions

1. This chart must always begin on page 2, 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.

2. 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 or add to the language unless the language inaccurately portrays the health benefit plan design.

3. 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 in the *Answers* column and indicate, using the terms to describe provider networks used in the health benefit plan documents or policy, to which the amounts apply. For example, if a 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 *Answers* column should show "$2,000 preferred provider, $5,000 non-preferred provider.”

B. Important Question 1. *What Is The Overall Deductible?:*

1. *Answers* column:

a. If there is no overall deductible, answer "$0.”

b. If there is an overall deductible, answer with the dollar amount.

c. 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 individual / $3,000 family”).

2. *Why This Matters* column:

a. 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.”

b. If there is an overall deductible, show the following language: “Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.”

c. If portraying family coverage for which there is an embedded deductible, plans and issuers must include the following language: “If you have other family members on the policy, they have to meet their own deductible until the overall family deductible amount has been met.”

d. If portraying family coverage for which there is a non-embedded deductible, plans and issuers must include the following language: “If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.”

C. Important Question 2. *Are there services covered before you meet your deductible?:*

1. *Answers* column:

a. If there are no services covered before the deductible is met, answer "No.”

b. If there are services covered before the deductible is met, plans and issuers must answer “Yes” and list major categories of covered services that are NOT subject to the deductible, for example, preventive care and generic drugs.

2. *Why This Matters* column:

a. If there are no services covered before the deductible, show the following language: “See the Common Medical Events chart below for your costs for services this plan covers.”

b. If there are services covered before the deductible is met, show the following language: “This plan covers some items and services even if you haven’t yet met the annual deductible amount. But a copayment or coinsurance may apply. See the Common Medical Events chart below.”

D. Important Question 3. *Are there other deductibles for specific services?:*

1. *Answers* column:

a. If the overall deductible is the only deductible, answer with the phrase “No.”

b. If there are other deductibles, answer “Yes.”

2. *Why This Matters* column:

a. 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.”

b. If there are other deductibles, the plan or issuer must show the following language: “Some specific services have their own deductible you must pay before the plan begins to pay. See the Common Medical Events chart below.”

E. Important Question 4. *What is the Out-of-Pocket Limit for this Plan?:*

1. *Answers* column:

a. If there are no out-of-pocket limits, respond “No out-of-pocket limit.”

b. If there is an out-of-pocket limit, respond with a specific dollar amount that applies in each coverage period. For example: “$5,000.”

c. 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 individual / $3,000 family”).

d. 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 individual / $5,000 family; for nonparticipating providers $4,000 individual / $8,000 family.”

2. *Why This Matters* column:

a. 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 in a year for covered services.”

b. If portraying family coverage for which there is an embedded out-of-pocket limit, plans and issuers must include the following language: “If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.”

c. If portraying family coverage for which there is a non-embedded out-of-pocket limit, plans and issuers must include the following language: “If you have other family members in this plan, the overall family out-of-pocket limit must be met.”

F. Important Question 5. *What Is Not Included In The Out-of-Pocket Limit?:*

1. *Answers* column:

a. If there is no out-of-pocket limit, indicate “This plan has no out-of-pocket limit.”

b. 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. At the plan or issuer's discretion the list may also include, if applicable, other amounts that don't count towards the out-of-pocket limit, such as out-of-network cost sharing or penalties for failure to obtain pre-authorization for services.

c. If there is no out-of-pocket limit on out-of-network services, the plan or issuer must always include the following: "Premiums, health care this plan doesn't cover, and any charges from out-of-network providers."

d. If there is an out-of-pocket limit on out-of-network services, the plan or issuer must always include the following: "Premiums, health care this plan doesn't cover, charges from out-of-network providers above the plan's allowed amount."

2. *Why This Matters* column:

a. 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."

b. If cost sharing for specific services listed in the Common Medical Event section of the SBC doesn't count towards the out-of-pocket limit, then the plan or issuer must include the statement, "The Common Medical Events chart in this SBC has more information about costs that don't count towards the out-of-pocket limit."

c. 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."

G. Important Question 6. *Will you pay less if you use a network provider?*

1. *Answers column:*

a. If this health benefit plan does not use a network, the plan or issuer must respond, "No."

b. If there is simple in-network/out-of-network coverage, the plan or issuer should say "Yes. See [insert hyperlink to provider directory]."

c. If a plan or issuer uses a tiered network, the plan or issuer should say "Yes. See [insert hyperlink to provider directory]."

2. *Why This Matters column*:

a. If the health benefit plan does not use a network, this language must be used: "You can receive covered services from any provider."

b. If there is simple in-network/out-of-network coverage, this language must be used: "This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill)."

c. If a plan or issuer uses a tiered network, this language must be used: "You pay the least if you use a provider in [insert tier name] network. You pay more if you use a provider in [insert tier name]. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill)."

d. If item b or item c above applies, this language must also appear: "Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services."

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

1. *Answers* column:

a. If there is a referral required, the plan or issuer should show "Yes."

b. If there is no referral required, the plan or issuer should show "No."

2. *Why This Matters* column:

a. Plans and issuers should specify whether the need for a referral is different for different benefits.

b. 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 a referral before you see the specialist."

c. If there is no referral required, the plan or issuer must show the following language: "You can see the specialist you choose without a referral."

IV. COMMON MEDICAL EVENTS

A. Disclaimer at top of Common Medical Event Chart

1. The disclaimer at the top of the Common Medical Event Chart should be replicated without changes to the font size, graphic or formatting.

2. Plans and issuers should insert whichever of the following sentences accurately describes the deductibles and SBC:

a. All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

b. The overall deductible does not apply to benefits [subject to a copayment or coinsurance] unless stated below.

c. Plans and issuers are to modify (b) above to accurately reflect the health benefit plan, including either copayment, or overall deductible, or both, or neither, as appropriate.

3. Plans and issuers should include a second sentence using the following language: REMEMBER, definitions of underlined terms can be found in the Glossary at [www.insertHHSmicrosite.gov]

B. Overarching Instructions

1. Location of Chart: This chart must always begin on the page after Question 7 "Do I need a referral…." The rows shown in the Common Medical Events chart must appear in the same order. However, the rows shown may extend to additional pages if necessary. The heading of the chart must appear on the top of all pages used.

2. Consumer testing indicates that consistent terminology is important in this section. Consistent terms should be used throughout the SBC. As much as possible terms in the SBC should mirror plan documents, or mirror the glossary, or both. For example, don't use "copay" and "co-pay." Don't use "cost share" and "cost sharing."

3. Consumer testing indicates that bullets and blank space would be helpful to distinguish different concepts on this chart. Plans and issuers are encouraged to use such formatting options if space permits.

4. "*You will pay…*" column(s): The template assumes simple in/out of network coverage. If a plan or issuer uses a more complex tiered network, then the middle column(s) should say "You will pay more."

    a. Plans and issuers may vary the number of columns depending upon the type of coverage and the number of preferred provider networks. Non-network plan types may use one column.

    b. If cost sharing applies to multiple network tiers or is the same in and out of network, then plans and issuers may merge and center the cells for that listed service to display a single cost sharing amount. For example if cost sharing is the same for an emergency in or out of network, the cells could be merged and centered to indicate that the cost sharing is the same for both in and out of network.

    c. For the purposes of copayments and coinsurance, the columns are intended to reflect the most common consumer costs, after the deductible has been satisfied, if the deductible applies.

    d. Plans and issuers should denote in these columns up to three significant exceptions, such as when a specific service is subject to a separate deductible, is covered before the overall deductible, or is covered at no cost. Significance is determined by the plan or issuer based on two factors: services with historically high utilization and financial impact on an individual.

    e. 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 reference to any network should be deleted for non-network plan types with only one column.

f. 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.” Column labels must always include the phrases “(You will pay the least)” and “(You will pay the most)” for in-network and out-of-network columns respectively. If there is a middle tier, include “(You will pay more).” For non-network plan types, eliminate the sub-headings and just use the main column title “What You Will Pay.”

g. For plan types providing no out-of-network benefits, the plan or issuer should insert “Not covered” in the out-of-network column (which, for coverage providing out-of-network benefits, would usually be out-of-network provider or non-preferred provider column).

h. Plans and issuers must complete the responses in the “*You will pay …*” column(s) based on how the plan or issuer covers the specific services listed in the chart after the deductible has been satisfied. Fill in the “*You will pay …*” column(s) with:

   1. the coinsurance percentage if only coinsurance applies for this service in all cases (e.g., 20% coinsurance);

   2. the copayment amount if only a copayment applies for this service in all cases (e.g. $10/visit);

   3. “No charge” or “0% coinsurance after deductible” if the deductible is the only cost sharing applied to this service in all cases;

   4. “No charge” if the employee pays nothing;

   5. “Not covered” if the service is not covered by the health benefit plan; or

   6. the deductible, copayment, and/or coinsurance amount, and the order in which cost sharing applies, when more than one type of cost sharing applies to a service in some or all cases (e.g., “20% coinsurance after deductible” or “$10/visit for first 3 visits, then $2,000 deductible, then 20% coinsurance after deductible.”

   When referring to coinsurance, include a percentage valuation. For example: 20 % coinsurance. When referring to copayments, include a per occurrence cost. For example: $20/visit or $15/prescription. Plans and issuers should never use the term “deductible” to apply to a per occurrence cost.

i. Refer to the specific additional instructions below for details on completing the columns in the chart for the following common medical events:

   - If you visit a health care provider’s office or clinic;
   - If you need prescription drugs to treat your illness or condition;

- If you have outpatient surgery
- If you have a hospital stay
- If you need mental/ behavioral health or substance abuse services
- If you are pregnant

5. *Limitations, Exceptions and Other Important Information* column:

   a. In this column, list the significant limitations, exceptions and important information for each service listed. This column must indicate:

      1. when a service category or a substantial portion of a service category is excluded from coverage (e.g., column should indicate "brand name drugs excluded" in health benefit plans that only cover generic drugs);

      2. when cost sharing for covered in-network services does not count toward the out-of-pocket limit;

      3. limits on the number of visits or on specific dollar amounts payable under the health benefit plan; and

      4. when prior authorization is required for services.

      Significance of other limitations, exceptions and important information is determined by the plan or issuer based on two factors: services with historically high utilization and financial impact on an individual. A plan or issuer may include as important information coverage elements or features that provide more benefit to the consumer, such as the impact of wellness incentives or the option to elect an FSA. Plans and issuers should NOT use this box to identify services listed in "*Excluded Services*" or "*Other Covered Services*."

   b. In this column, information provided 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 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 *Excluded Services* 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 the *Excluded Services* box.

   d. If the health benefit plan has a pre-authorization requirement that includes a penalty when a member fails to obtain pre-authorization, such as a denial of payment for care that would otherwise be covered, or a reduced payment, the plan or issuer must include specific information about the penalty.

   e. If there are no items that meet the significance threshold in item a above, then the plan or issuer should show "--------." For each *Common Medical Event* in the chart, the plan or issuer should merge the boxes in the *Limitations, Exceptions and Other Important Information* column and display one response across

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

f. Refer to the specific additional instructions below for details on completing the *Limitations, Exceptions and Other Important Information* column in the chart.

6. If a group plan contracts with more than one issuer or vendor (for example when a pediatric dental benefit or drug coverage is handled under a separate contract from the medical plan) to provide services under the plan and will provide more than one SBC, then the issuer or vendor that is NOT covering a particular benefit or benefits should follow the instructions below. Each Common Medical Event that is not included in this plan should be addressed as follows:

   a. The "*You will pay …*" column(s) should be left blank.

   b. The *Limitations, Exclusions and Other Important Information* columns should state, "This benefit is not covered by this portion of the plan. A separate Summary of Benefits and Coverage will be provided describing the benefit coverage."

   c. In the case of prescription drug coverage, remove the sentence "More information about prescription drug coverage is available at www.[insert]." from the additional row that spans the "*You will pay…*" and *Limitations, Exclusions and Other Important Information* columns.

C. Common Medical Event 1 – If you visit a health care provider's office or clinic

1. The plan or issuer should always include, in a separate paragraph at the end of the *Limitations, Exceptions and Other Important Information* column, the following language, "You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for." If the issuer does not combine the services (the rows) for this Common Medical Event into one box, this statement should always appear in line with "Preventive care/screening/immunization."

IMPORTANT NOTE TO CCIIO, DOL and IRS ("the Tri-Agencies"):

In its discussions regarding the preventive service information, the NAIC's Consumer Information Subgroup extensively discussed the lack of information about preventive services. As a result, consumers do not have the benefit of knowing which preventive services will be covered with no cost sharing and which will be subject to cost sharing. The group determined the lack of information is a significant consumer issue. The Consumer Information Subgroup strongly recommends that the Tri-Agencies develop a consumer-friendly website, similar to what has already been developed for Medicare beneficiaries, where consumers can go on their own or be directed to by their plan or issuer for more information about preventive services. The website should clearly identify what services are required to be covered under a health benefit plan, noting new preventive service additions and identify when plans and issuers would be expected to provide coverage for those services.

An example of the resources available to Medicare beneficiaries, which the Subgroup recommends the agencies replicate, can be found: http://www.medicare.gov/coverage/mammograms.html

D. Common Medical Event 2 – If you have a test

No specific instructions for this event. Refer to Overarching Instructions.

E. Common Medical Event 3 – If you need prescription drugs to treat your illness or condition

1. All plans and issuers should include a row that spans across the top of the *Services You May Need*, *You will pay*… and *Limitations, Exceptions and Other Important Information* columns and says the following: "For more information about prescription drug coverage, what drugs are covered and your cost, see: [insert hyperlink or phone number]" This should be a link to the website location where the participant or beneficiary can find more information about prescription drug coverage for this health benefit 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 health benefit plan.

2. Under the *Services You May Need* column, the plan or issuer should list the categories of prescription drug coverage using the same terminology used in the formulary, in the policy or plan document and on the website listed in the added row "For more information…" After describing the category, the plan or issuer should include a parenthetical describing the category of drugs in terms of its cost to the consumer using language similar to the following, as appropriate: "(You will pay less of the cost)"/ "(You will pay more of the cost)" / "(You will pay even more of the cost)" / "(Additional higher cost options)" For example, the issuer might fill out 4 rows with the terms, "Tier 1 (You will pay less of the cost)", "Tier 2 (You will pay more of the cost)", "Tier 3 (You will pay even more of the cost)", and "Tier 4 (Additional higher cost option)."

3. Plans and issuers should use as many rows as necessary to accurately reflect the health benefit plan design.

4. Under the "*You will pay…."* column(s), plans and issuers should include the cost sharing for both retail and mail order, as applicable.

5. Plans and issuers may, at their option, add a row for mail order prescription drugs if the additional row helps to provide greater clarity to consumers as to the benefit.

F. Common Medical Event 4 – 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, Exceptions and Other Important Information* column. Significance of such expenses is determined by the plan or issuer based on two factors: historically high utilization 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% coinsurance", but the *Limitations, Exceptions and Other Important Information* column might show "50% coinsurance for radiology."

G. Common Medical Event 5 – If you need immediate medical attention

No specific instructions for this event. Refer to Overarching Instructions.

H. Common Medical Event 6 – If you have a hospital stay

1. If there are significant expenses associated with a typical hospital stay that have higher cost sharing than the facility fee or physician/surgeon fee, or are not covered, then that must be shown under the *Limitations, Exceptions and Other Important Information* column. Significance of such expenses is determined by the plan or issuer based on two factors: historically high utilization 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% coinsurance", but the *Limitations, Exceptions and Other Important Information* column might show "50% coinsurance for anesthesia."

I. Common Medical Event 7 – If you need mental/ behavioral health or substance abuse services

1. If the cost sharing differs for outpatient services for mental/behavioral health services or substance abuse services 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."

J. Common Medical Event 8 – If you are pregnant

1. If applicable, plans and issuers should include an explanation in the *Limitations, Exceptions and Other Important Information* column that describes that the cost sharing amounts listed may not apply to some services. The issuer should determine which, if any, of the following sentences to include in the *Limitations, Exceptions and Other Important Information* column: "No cost sharing for preventive services." "Depending on the type of services, a [copayment, coinsurance or deductible] may apply." "Maternity care may include tests and services described elsewhere in the SBC ([ultrasound, specialist services, etc.])."

K. Common Medical Event 9 – If you need help recovering or have other special health needs

1. Physical Therapy, Occupational Therapy and Speech Therapy services must be listed in the *Limitations, Exceptions and Other Important Information* column for the Rehabilitation services and Habilitation services rows.

2. If there is a quantitative limit (e.g., number of days, hours, visits covered) applicable to that service, those limits must be specified.

3. If the service is not covered, then the plan or issuer should include the statement, "Not covered."

L. Common Medical Event 10 – If your child needs dental or eye care

No specific instructions for this event. Refer to Overarching Instructions.

V. GENERAL INFORMATION

The *General Information about this Plan, Grievances and Appeals,* Minimum Essential Coverage/Minimum Value Standard, *Language Access* Services (if applicable), and *Coverage Examples* sections must always appear in the order shown.

A. *Excluded Services* (Services Your Plan Does Not Cover) and *Other Covered Services*

1. Each plan or issuer must place all services listed below in either the *Excluded Services* box or the *Other Covered Services* box according to the plan or policy provisions. The required list of services includes:

• Acupuncture	• Non-emergency care when traveling outside the U.S.
• Bariatric surgery	• Private-duty nursing
• Chiropractic care	• Routine eye care (adult)
• Cosmetic surgery	• Routine foot care
• Dental care (adult)	• Weight loss programs
• Hearing aids	• Long-term care
• Infertility treatments	

2. 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 *Excluded Services* box. Plans and issuers should **NOT** duplicate services that are already listed as excluded or 100% coinsurance in the *Limitations, Exclusions and Other Important Information* column of the Common Medical Events chart.

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

4. 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."

***Note to the Tri-Agencies**: The Subgroup members found that the instructions are insufficient for describing coverage of services provided outside the US. For group health benefit plans, is this meant to apply to non-emergency services, as indicated in the required items listed under #1 above? Is it meant to address expatriate health benefit plans?*

5. If the plan or issuer provides limited coverage for any of the services listed in item 1 above, the limitation must be stated in the *Excluded Services* 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 *Excluded Services* box, as follows: "Acupuncture unless it's prescribed by a physician for rehabilitation purposes." Alternatively, the prescribed statement could be in the *Other Covered Services* box, as follows: "Acupuncture if it's prescribed by a physician for rehabilitation purposes."

6. For example, if a plan or issuer excludes all of the services on the list above except Chiropractic services, and also showed exclusion of Cosmetic Surgery in the Common Medical Events chart, the *Other Covered Services* box would show "Chiropractic Care" and the *Excluded Services* box would show "Acupuncture, Bariatric Surgery, Cosmetic surgery, Dental care (Adult), 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."

7. If the plan or issuer provides coverage for the diagnosis of infertility, but not the services that treat the infertility (e.g., IVF, prescription drugs, etc.), Infertility Treatment should be listed in the *Excluded Services* box.

8. FOR QUALIFIED HEALTH PLANS: For an SBC prepared for a qualified health plan (QHP) offered through a Marketplace, the issuer must reflect whether abortion services are covered. Qualified Health Plans that cover excepted and non-excepted abortion services must list "abortion" in the Other Covered Services box. Qualified Health Plans that exclude all abortions should list "abortion" in the Excluded Services box. Qualified Health Plans that cover only excepted abortions should list in the *Excluded Services* box "abortion (except in cases of rape, incest, or when the life of the mother is endangered)" and may also include a cross-reference to policy or plan document that more fully describes the exceptions.

    a. With respect to Multi-State Plans, the Office of Personnel Management may issue additional instructions. Multi-State Plan issuers are directed to comply with such instructions with respect to disclosure regarding coverage or exclusion of abortion services.

IMPORTANT NOTE TO CCIIO, DOL and IRS ("the Tri-Agencies"):

The Subgroup discussed the placement of a disclosure about coverage of abortion services. The Subgroup ultimately agreed to leave the disclosure as proposed in the NPRM. However, the Subgroup noted the difficulty consumers would have in comparing coverages between QHPs and non-QHPs as to this coverage. The Subgroup also noted the potential for all consumers, regardless of their personal beliefs, to want full transparency about the existence or non-existence of coverage of this specific service. The Subgroup discussed ways to address these concerns and identified two. First, the Tri-Agencies could consider modifying applicable regulations to make the disclosure requirement applicable to all plans and issuers. Alternatively, the Tri-Agencies could modify the proposed instructions to make it clear that non- QHPs may also provide the disclosures, where appropriate, as either an "Excluded Service" or "Other Covered

Service." ***The last process would permit plans and issuers to comply with any state disclosure requirements.***

B. YOUR RIGHTS: GRIEVANCES, APPEALS AND CONTINUATION OF COVERAGE

1. Issuers should include the following paragraph with no variation, directly following *Other Covered Services*:

   "There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a Grievance or Appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or grievance for any reason to your plan. There are also agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies:"
   [Insert agency contact information]

2. Plans and issuers should insert the following agency contact information, as applicable, for the agencies that have oversight for the health benefit plan. A chart is suggested here but is not required. Plans and issuers should not repeat any organization's or agency's contact information, but should note all the areas where each agency or organization can assist.

3. For example, a state insurance department would not have jurisdiction over a self-funded plan and should not be listed. But a Consumer Assistance Program, even if operated by a state insurance department, can still assist members of a self-funded plan, and therefore should be listed.

[State insurance department contact information]	Complaints Grievances Appeals External Review Continuation of Coverage
[Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html]	Complaints Grievances Appeals Continuation of Coverage
[State consumer assistance program, if other than state insurance department – provide state-specific contact information available from http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/]	Complaints Grievances Appeals Continuation of Coverage
[Office of Personnel Management Multi State Plan Program : https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/]	External Review

[Healthcare.gov www.HealthCare.gov or call 1-800-318-2596][state health insurance marketplace or SHOP]	Other coverage options

C. MINIMUM ESSENTIAL COVERAGE/MINIMUM VALUE STANDARD

The following questions and statements must appear, immediately following, YOUR RIGHTS: GRIEVANCES, AND APPEALS AND CONTINUATION OF COVERAGE and the issuer must provide the appropriate answer for each health benefit plan.

Does this plan provide Minimum Essential Coverage? [Yes/No]

If you don't have Minimum Essential Coverage, you'll have to pay a penalty unless you get an exemption from the requirement that you have health coverage.

Does this plan meet Minimum Value Standard~~s~~? [Yes/No]

If your plan doesn't meet the Minimum Value Standard~~s~~, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

D. LANGUAGE ACCESS SERVICES – taglines, culturally and linguistically appropriate requirements (if applicable):

1. 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.

VI. Coverage Examples: Calculating Cost Sharing

1. The items at the top of each coverage example stating the overall deductible and applicable copayment and coinsurance amounts should be the same as the in-network cost sharing amounts (or the applicable cost sharing amounts for non-network plan types) previously stated in the various sections of the SBC.

    a. Cost sharing for self-only coverage should be used.

    b. In addition, plans and issuers that use networks, including tiered networks, should use the cost sharing from the most favorable network tier. For example, the overall deductible provided on page 2 should be repeated as the first bullet point for each coverage example. As another example, the specialist copayment amount for "Peg is Having a Baby" should be the amount stated in the left-most "*You will pay…*" column for Common Medical Event #8 – "Office Visits" for a tiered network health benefit plan.

    c. If any of the items are not applicable to the health benefit plan, plans and issuers may state "N/A" for that item, or "none", or may use or "$0", or "0%" or other method for indicating the item is not applicable to that health benefit plan. Plans and issuers are encouraged to use "N/A" or "none" for such items to the extent that it's technically feasible to use text instead of zeros.

2. The U.S. Department of Health and Human Services (HHS) will provide all plans and issuers with standardized data to be utilized for in the Total Example Cost row for the coverage examples.

    a. HHS will also provide underlying detail that will allow plans and issuers to calculate *Cost Sharing* amounts, including: Date of Service, medical coding information, Provider Type, Category, descriptive Notes identifying the specific service provided, and Allowed Amounts.

    b. 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.

3. Each plan or issuer must calculate cost sharing, using the detailed data provided by HHS, and populate the *Cost Sharing* fields.

    a. Dollar values are generally to be rounded off to the nearest round number in dollars in order to reinforce to consumers that numbers in the examples 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 Coverage Examples.

    b. 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."

4. Services on the template provided by HHS are listed individually for classification and pricing purposes to calculate the amounts for the *Cost Sharing* section. HHS specifies the Category used to roll up detail costs into the categories listed above the "Total Example Cost" row. Some plans and issuers 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 health benefit plan in order to complete the *Cost Sharing* section, but must leave the categories listed above the "Total Example Cost" row as is. Examples of categories that might differ between the *Cost Sharing* section and the categories listed above the "Total Example Cost" row could include, but are not limited to:

    a. Payment of services based on the location where they are provided (inpatient, outpatient, office, etc.)

    b. Payment of items as prescription drugs vs. medical equipment

5. Each plan or issuer must calculate and populate the *Cost Sharing* section based upon the cost sharing and benefit features of the health benefit 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).

a. Deductible(s) - includes everything the participant or beneficiary pays up to the deductible amount(s). Any copayments that accumulate toward the deductible(s) are accounted for in this cost sharing category, rather than under copayments.

b. Copayment - those copayments that don't apply to the deductible(s).

c. Coinsurance - anything the participant or beneficiary pays above the deductible(s) that's not a copayment or non-covered service. This should be the same figure as the Total less the Deductible, Copayments and Excluded Services.

d. Excluded Services - anything the participant or beneficiary pays for non-covered services or services that exceed coverage limits.

6. If the plan or issuer has a wellness program that varies the deductibles, copayments, coinsurance, or coverage for any of the services listed in a treatment scenario, the plan or issuer must complete the calculations for that treatment scenario assuming that the patient is NOT participating in the wellness program.

7. If all of the costs associated with the Coverage Examples are excluded under the health benefit plan, then the entire "Total Example Cost" amount should also appear on the lines for "Excluded services" and "The total [Peg][Joe][Mia] would pay is:". The Cost Sharing lines should be left blank.

8. If a group plan contracts with more than one issuer or vendor (for example when a pediatric dental benefit or drug coverage is handled under a separate contract from the medical plan) to provide services under the plan, and:

    a. More than one SBC will be provided: The issuer or vendor that is NOT covering a particular benefit or benefits should not include any coverage information in the Coverage Examples for that benefit. For example, if prescription drug coverage is handled by a separate issuer, then the issuer covering medical benefits and preparing an SBC for medical benefits should reflect all the prescription drug costs in the "Excluded services" line for the medical benefits SBC.

    b. A group plan sponsor will combine separate SBCs from different issuers or vendors to provide a single SBC to participants or beneficiaries: The group plan sponsor should also prepare one Coverage Example, likewise combining the information supplied by various issuers or vendors.

Summary of Benefits and Coverage:
What This Plan Covers & What You Pay for Covered Services
Instruction Guide for Individual Health Insurance

Edition Date: FINAL 10/06/2015

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

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

A. Form language and formatting must be reproduced, unless instructions allow or instruct otherwise. The issuer must use 12-point font, and replicate all symbols, formatting, bolding, and shading where applicable. 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 charts or sections to begin or end abruptly. In such cases, it may be more appropriate for issuers to utilize other font types to reproduce an SBC in a manner that is consistent with the SBC template format, avoiding too much empty space within sections and the beginning of another.

B. Special Rule: To the extent a health benefit 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 issuer must accurately describe the relevant health benefit 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.

1. Such situations may occur, for example, if a health benefit plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a health benefit plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where an issuer is denoting the effects of a related health flexible spending arrangement (health FSA) or a health reimbursement arrangement (HRA), or if a health benefit plan provides different cost sharing based on participation in a wellness program. If participation in a wellness program or other arrangement is optional, the *Answers* column in the Coverage Overview and the "*You will pay…"* column(s) in the Common Medical Events chart, and the Coverage Examples, should always reflect the basic health benefit plan for comparison purposes. Issuers may choose to note the impact of other optional features, such as wellness programs, on cost sharing amounts in the *Limits, Exclusions and Other Important Information* column in the Common Medical Events chart.

2. Additional examples of flexibility available under this Special Rule include:

a. Issuers may combine information for different coverage tiers in one SBC, provided the appearance is understandable.

b. If the individual is able to select different coverage levels (i.e., self-only vs. family) with associated different levels of deductibles, copayments, and coinsurance for a particular benefit package, 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. For example, on the Coverage Overview page, in the *Answers* column related to deductible, information entered could look like this: "$2,000 individual / $4,000 family." 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.

c. Issuers may not modify information in the *You will pay…* column(s) to reflect impact of add-ons to major medical coverage that could affect cost sharing (such as a health FSA, HRA, health savings account (HSA), or wellness program). Information about add-ons can be noted in the *Limits, Exclusions and Other Important Information* column in the Common Medical Events chart.

d. Issuers may collapse the two lines under "If you are pregnant" in the Common Medical Event charts if the health benefit plan uses the global maternity CPT code.

C. Issuers must customize all identifiable company information throughout the document, including websites and telephone numbers.

D. Minor adjustments are permitted to row or column size or margins in order to accommodate the health benefit 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.

E. This document has 4 Parts: (1) *Coverage Overview,* (2) *Common Medical Events,* (3) *General Information,* and (4) *Coverage Examples.* Issuers must start each section on a new page, in order, with the title at the top. Sections may continue onto subsequent pages, with the title indicating it is a continuation at the top. The bottom of each page must indicate what section comes next, for example, "Coverage Overview continued on next page" or "Next: Common Medical Events", as appropriate.

F. For all form sections to be filled out by the issuer (particularly in the *Answers* column in Part (1) *Coverage Overview*, and the *Limitations, Exceptions and Other Important Information* column in Part (2) *Common Medical Events*), the 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. An issuer may make slight modifications to any required language to be inserted within the SBC if such slight modification is reasonably designed to ensure accuracy or to improve readability due to policy language.

G. The SBC is not permitted to substitute a cross-reference to other documents for any content element of the SBC.

H. Barcodes, control numbers, or other similar language may be added to SBCs by issuers for quality control purposes. Page numbers may be relocated along the bottom of pages to accommodate barcodes, control numbers or other similar language.

I. With respect to these SBC instructions, the Office of Personnel Management (OPM) may provide additional instructions for Multi-State Plan issuers.

J. For questions about completing the SBC, contact the Department of Health and Human Services at SBC@cms.hhs.gov.

K. Terms that are defined in the Glossary should be underlined in the SBC. Issuers providing an electronic SBC should make sure defined terms hyperlink directly to the Glossary, ideally directly to the definition in the Glossary for that term.

Note to Tri-Agencies: ***The subgroup recommends that you develop a static microsite as a single click source for the glossary. Neither of the websites in the NPRM are specific and require consumers to hunt for the document they actually want. This eliminates any need for issuers to customize this piece of the SBC and will be beneficial over time as consumers learn there is one gold standard location for this document. Additionally, technology embedded into the SBC that allows consumers to put the cursor over a glossary term and see the definition without going to a separate website would be best.***

II. Header and footer information: Top and Bottom of page 1

A. Header: The header must be included on the first page of the SBC, but may also be included on other subsequent pages of the SBC at the option of the issuer.

B. Top Left Header (page 1):

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

   a. First line: Show the health benefit plan name and insurance company name in bold. Example: “Maximum Health Plan: Alpha Insurance Group.”

   b. Issuers have the option to use their logo instead of typing in the company name if the logo includes the name of the entity issuing the coverage.

   c. The header may roll onto a third line if all required information cannot fit into two lines.

   d. The issuer must use the commonly known company name.

   e. Health benefit plan names may be generic, such as standard or high option. Additionally, the issuer’s name and the health benefit plan name are interchangeable in order.

C. Top Right Header (page 1):

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

a. First line: After Coverage Period, the issuer must show the beginning and end dates for the applicable coverage period (such as policy year) in the following format: “MM/DD/YYYY - MM/DD/YYYY.” For example: “Coverage Period: 01/01/2016 - 12/31/2016.”

b. If the coverage period end date is not known when the SBC is prepared, the issuer is permitted to insert only the beginning date of the coverage period. For example: “Coverage Period: Beginning on or after 01/01/2016.”

c. If the SBC is being provided to satisfy the notice of material modification requirements, the 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.”

d. The dates listed for the coverage period may reflect the coverage period for the policy as a whole, not the period applicable to each individual. Therefore, if a health benefit plan is a calendar year plan and an individual enrolls on January 19, the coverage period is permitted to be the calendar year. Issuers are not required to individualize the coverage period for each individual's enrollment.

2. Second line on the right:

a. After *Coverage for*: indicate who the coverage is for (such as Individual, Individual + Spouse, Family).

b. The issuer should use the terms used in the policy documents.

c. After *Plan Type*: indicate the type of coverage, such as HMO, PPO, POS, Indemnity, or High-deductible.

D. Title - centered at the top of Page 1:

1. Issuers must include the title “Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services”

E. Disclaimer - bottom of Page 1:

1. The disclaimer at the bottom of page 1 should be replicated exactly, without changes to the font size, graphic, or formatting.

2. The issuer should insert the following phrase: “For more information about this plan, or to get a copy of the plan documents, contact the plan [insert toll-free phone number] or [insert website]. Issuers in a merged market (combining individual and group markets) should refer to the Individual Instructions.

III. COVERAGE OVERVIEW on Page 2:

A. General Instructions

1. This chart must always begin on page 2, and the rows must always appear in the same order. Issuers must complete the *Answers* column for each question on this chart, using the instructions below.

2. Issuers must show the appropriate language in the *Why This Matters* box as instructed in the instructions below. Issuers must replicate the language given for the *Why This Matters* box exactly, and may not alter or add to the language unless the language inaccurately portrays the health benefit plan design.

3. 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 in the *Answers* column and indicate, using the terms to describe provider networks used in the health benefit plan documents or policy, to which the amounts apply. 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 *Answers* column should show "$2,000 preferred provider, $5,000 non-preferred provider."

B. Important Question 1. *What Is The Overall Deductible?:*

1. *Answers* column:

   a. If there is no overall deductible, answer "$0."

   b. If there is an overall deductible, answer with the dollar amount.

   c. 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 individual / $3,000 family").

2. *Why This Matters* column:

   a. 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."

   b. If there is an overall deductible, show the following language: "Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay."

   c. If portraying family coverage for which there is an embedded deductible, issuers must include the following language: "If you have other family members on the policy, they have to meet their own deductible until the overall family deductible amount has been met."

   d. If portraying family coverage for which there is a non-embedded deductible, issuers must include the following language: "If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay."

C. Important Question 2. *Are there services covered before you meet your deductible?:*

1. *Answers* column:

    a. If there are no services covered before the deductible is met, answer "No."

    b. If there are services covered before the deductible is met, issuers must answer "Yes" and list major categories of covered services that are NOT subject to the deductible, for example, preventive care and generic drugs.

2. *Why This Matters* column:

    a. If there are no services covered before the deductible, show the following language: "See the Common Medical Events chart below for your costs for services this plan covers."

    b. If there are services covered before the deductible is met, show the following language: "This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. See the Common Medical Events chart below."

D. Important Question 3. *Are there other deductibles for specific services?:*

1. *Answers* column:

    a. If the overall deductible is the only deductible, answer with the phrase "No."

    b. If there are other deductibles, answer "Yes."

2. *Why This Matters* column:

    a. If there are no other deductibles, the issuer must show the following language: "You don't have to meet deductibles for specific services."

    b. If there are other deductibles, the issuer must show the following language: "Some specific services have their own deductible you must pay before the plan begins to pay. See the Common Medical Events chart below."

E. Important Question 4. *What is the Out-of-Pocket Limit for this Plan?:*

1. *Answers* column:

    a. If there are no out-of-pocket limits, respond "No out-of-pocket limit."

    b. If there is an out-of-pocket limit, respond with a specific dollar amount that applies in each coverage period. For example: "$5,000."

    c. 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 individual / $3,000 family").

d. 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. Issuers should use the terminology in the policy (e.g., in-network, participating, or preferred). For example: “For participating providers $2,500 individual / $5,000 family; for nonparticipating providers $4,000 individual / $8,000 family.”

2. *Why This Matters* column:

a. If there is an out-of-pocket limit, the issuer must show the following language: “The out-of-pocket limit is the most you could pay in a year for covered services.”

b. If portraying family coverage for which there is an embedded out-of-pocket limit, issuers must include the following language: “If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.”

c. If portraying family coverage for which there is a non-embedded out-of-pocket limit, issuers must include the following language: “If you have other family members in this plan, the overall family out-of-pocket limit must be met.”

F. Important Question 5. *What Is Not Included In The Out-of-Pocket Limit?:*

1. *Answers* column:

a. If there is no out-of-pocket limit, indicate “This plan has no out-of-pocket limit.”

b. If there is an out-of-pocket limit, the 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. At the issuer’s discretion the list may also include, if applicable, other amounts that don’t count towards the out-of-pocket limit, such as out-of-network cost sharing or penalties for failure to obtain pre-authorization for services.

c. If there is no out-of-pocket limit on out-of-network services, the issuer must always include the following: "Premiums, health care this plan doesn't cover, and any charges from out-of-network providers."

d. If there is an out-of-pocket limit on out-of-network services, the issuer must always include the following: "Premiums, health care this plan doesn't cover, charges from out-of-network providers above the plan's allowed amount."

2. *Why This Matters* column:

a. If there is an out-of-pocket limit, the issuer must show the following language: “Even though you pay these expenses, they don’t count toward the out-of-pocket limit.”

b. If cost sharing for specific services listed in the Common Medical Event section of the SBC doesn’t count towards the out-of-pocket limit, then the issuer must

include the statement, “The Common Medical Events chart in this SBC has more information about costs that don’t count towards the out-of-pocket limit.”

c. 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.”

G. Important Question 6. *Will you pay less if you use a network provider?*

1. *Answers column:*

a. If this health benefit plan does not use a network, the issuer must respond, "No."

b. If there is simple in-network/out-of-network coverage, the issuer should say “Yes. See [insert hyperlink to provider directory].”

c. If an issuer uses a tiered network, the issuer should say “Yes. See [insert hyperlink to provider directory].”

2. *Why This Matters column:*

a. If the health benefit plan does not use a network, this language must be used: “You can receive covered services from any provider.”

b. If there is simple in-network/out-of-network coverage, this language must be used: “This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (a balance bill).”

c. If an issuer uses a tiered network, this language must be used: “You pay the least if you use a provider in [insert tier name] network. You pay more if you use a provider in [insert tier name]. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (a balance bill).”

d. If item b or item c above applies, this language must also appear: “Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.”

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

1. *Answers* column:

a. If there is a referral required, the issuer should show “Yes."

b. If there is no referral required, the issuer should show “No.”

2. *Why This Matters* column:

a. Issuers should specify whether the need for a referral is different for different benefits.

b. If there is a referral required, the 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 a referral before you see the specialist.”

c. If there is no referral required, the issuer must show the following language: “You can see the specialist you choose without a referral.”

IV. COMMON MEDICAL EVENTS

A. Disclaimer at top of Common Medical Event Chart

1. The disclaimer at the top of the Common Medical Event Chart should be replicated without changes to the font size, graphic or formatting.

2. Issuers should insert whichever of the following sentences accurately describes the deductibles and SBC:

   a. All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

   b. The overall deductible does not apply to benefits [subject to a copayment or coinsurance] unless stated below.

   c. Issuers are to modify (b) above to accurately reflect the health benefit plan, including either copayment, or overall deductible, or both, or neither, as appropriate.

3. Issuers should include a second sentence using the following language: REMEMBER, definitions of underlined terms can be found in the Glossary at [www.insertHHSmicrosite.gov]

B. Overarching Instructions

1. Location of Chart: This chart must always begin on the page after Question 7 “Do I need a referral…” The rows shown in the Common Medical Events chart must appear in the same order. However, the rows shown may extend to additional pages if necessary. The heading of the chart must appear on the top of all pages used.

2. Consumer testing indicates that consistent terminology is important in this section. Consistent terms should be used throughout the SBC. As much as possible terms in the SBC should mirror the policy, or mirror the glossary, or both. For example, don’t use “copay” and “co-pay.” Don’t use “cost share” and “cost sharing.”

3. Consumer testing indicates that bullets and blank space would be helpful to distinguish different concepts on this chart. Issuers are encouraged to use such formatting options if space permits.

4. “*You will pay…*” column(s): The template assumes simple in/out of network coverage. If an issuer uses a more complex tiered network, then the middle column(s) should say “You will pay more.”

a. Issuers may vary the number of columns depending upon the type of coverage and the number of preferred provider networks. Non-network plan types may use one column.

b. If cost sharing applies to multiple network tiers or is the same in and out of network, then issuers may merge and center the cells for that listed service to display a single cost sharing amount. For example if cost sharing is the same for an emergency in or out of network, the cells could be merged and centered to indicate that the cost sharing is the same for both in and out of network.

c. For the purposes of copayments and coinsurance, the columns are intended to reflect the most common consumer costs, after the deductible has been satisfied, if the deductible applies.

d. Issuers should denote in these columns up to three significant exceptions, such as when a specific service is subject to a separate deductible, is covered before the overall deductible, or is covered at no cost. Significance is determined by the issuer based on two factors: services with historically high utilization and financial impact on an individual.

e. Issuers should insert the terminology used in the policy 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. (Issuers should be aware that consumer testing has demonstrated that consumers more readily understand the terms “In-network” and “Out-of-network.”) The reference to any network should be deleted for non-network plan types with only one column.

f. 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.” Column labels must always include the phrases “(You will pay the least)” and “(You will pay the most)” for in-network and out-of-network columns respectively. If there is a middle tier, include “(You will pay more).” For non-network plan types, eliminate the sub-headings and just use the main column title “What You Will Pay.”

g. For plan types providing no out-of-network benefits, the issuer should insert “Not covered” in the out-of-network column (which, for coverage providing out-of-network benefits, would usually be out-of-network provider or non-preferred provider column).

h. Issuers must complete the responses in the “*You will pay …*” column(s) based on how the issuer covers the specific services listed in the chart after the deductible has been satisfied. Fill in the “*You will pay …*” column(s) with:

    1. the coinsurance percentage if only coinsurance applies for this service in all cases (e.g., 20% coinsurance);

2. the copayment amount if only a copayment applies for this service in all cases (e.g. $10/visit);

3. "No charge" or "0% coinsurance after deductible" if the deductible is the only cost sharing applied to this service in all cases;

4. "No charge" if the employee pays nothing;

5. "Not covered" if the service is not covered by the health benefit plan; or

6. the deductible, copayment, and/or coinsurance amount, and the order in which cost sharing applies, when more than one type of cost sharing applies to a service in some or all cases (e.g., "20% coinsurance after deductible" or "$10/visit for first 3 visits, then $2,000 deductible, then 20% coinsurance after deductible."

When referring to coinsurance, include a percentage valuation. For example: 20% coinsurance. When referring to copayments, include a per occurrence cost. For example: $20/visit or $15/prescription. Issuers should never use the term "deductible" to apply to a per occurrence cost.

i. Refer to the specific additional instructions below for details on completing the columns in the chart for the following common medical events:

- If you visit a health care provider's office or clinic;
- If you need prescription drugs to treat your illness or condition;
- If you have outpatient surgery
- If you have a hospital stay
- If you need mental/ behavioral health or substance abuse services
- If you are pregnant

5. *Limitations, Exceptions and Other Important Information* column:

a. In this column, list the significant limitations, exceptions and important information for each service listed. This column must indicate:

1. when a service category or a substantial portion of a service category is excluded from coverage (e.g., column should indicate "brand name drugs excluded" in health benefit plans that only cover generic drugs);

2. when cost sharing for covered in-network services does not count toward the out-of-pocket limit;

3. limits on the number of visits or on specific dollar amounts payable under the health benefit plan; and

4. when prior authorization is required for services.

Significance of other limitations, exceptions and important information is determined by the issuer based on two factors: services with historically high utilization and financial impact on an individual. An issuer may include as

important information coverage elements or features that provide more benefit to the consumer, such as the impact of wellness incentives or the option to elect an FSA. Issuers should NOT use this box to identify services listed in "*Excluded Services*" or "*Other Covered Services.*"

b. In this column, information provided 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 issuer requires the insured to pay 100 percent of a service in-network, then that should be considered an "excluded service" and should appear in the *Excluded Services* 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 the *Excluded Services* box.

d. If the health benefit plan has a pre-authorization requirement that includes a penalty when a member fails to obtain pre-authorization, such as a denial of payment for care that would otherwise be covered, or a reduced payment, the issuer must include specific information about the penalty.

e. If there are no items that meet the significance threshold in item a above, then the issuer should show "--------." For each *Common Medical Event* in the chart, the issuer should merge the boxes in the *Limitations, Exceptions and Other Important Information* column and display one response across multiple rows if such a merger would lessen the need to replicate comments and would save space.

f. Refer to the specific additional instructions below for details on completing the *Limitations, Exceptions and Other Important Information* column in the chart.

C. Common Medical Event 1 – If you visit a health care provider's office or clinic

1. The issuer should always include, in a separate paragraph at the end of the *Limitations, Exceptions and Other Important Information* column, the following language, "You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for." If the issuer does not combine the services (the rows) for this Common Medical Event into one box, this statement should always appear in line with "Preventive care/screening/immunization."

IMPORTANT NOTE TO CCIIO, DOL and IRS ("the Tri-Agencies"):

In its discussions regarding the preventive service information, the NAIC's Consumer Information Subgroup extensively discussed the lack of information about preventive services. As a result, consumers do not have the benefit of knowing which preventive services will be covered with no cost sharing and which will be subject to cost sharing. The group determined the lack of information is a significant consumer issue. The Consumer Information Subgroup strongly recommends that the Tri-Agencies develop a consumer-friendly website, similar to what has already been developed for Medicare beneficiaries, where consumers can go on their own or be directed to by their plan or

issuer for more information about preventive services. The website should clearly identify what services are required to be covered under a health benefit plan, noting new preventive service additions and identify when plans and issuers would be expected to provide coverage for those services.

An example of the resources available to Medicare beneficiaries, which the Subgroup recommends the agencies replicate, can be found: http://www.medicare.gov/coverage/mammograms.html

D. Common Medical Event 2 – If you have a test

No specific instructions for this event. Refer to Overarching Instructions.

E. Common Medical Event 3 – If you need prescription drugs to treat your illness or condition

1. Issuers should include a row that spans across the top of the *Services You May Need*, *You will pay*… and *Limitations, Exceptions and Other Important Information* columns and says the following: "For more information about prescription drug coverage, what drugs are covered and your cost, see: [insert hyperlink or phone number]" This should be a link to the website location where the insured can find more information about prescription drug coverage for this health benefit plan. If there is no website, provide a contact phone number where the insured can receive more information about prescription drug coverage for this health benefit plan.

2. Under the *Services You May Need* column, the issuer should list the categories of prescription drug coverage using the same terminology used in the formulary, in the policy and on the website listed in the added row "For more information…" After describing the category, the issuer should include a parenthetical describing the category of drugs in terms of its cost to the consumer using language similar to the following, as appropriate: "(You will pay less of the cost)"/ "(You will pay more of the cost)" / "(You will pay even more of the cost)" / "(Additional higher cost options)" For example, the issuer might fill out 4 rows with the terms, "Tier 1 (You will pay less of the cost)," "Tier 2 (You will pay more of the cost)," "Tier 3 (You will pay even more of the cost)," and "Tier 4 (Additional higher cost option)."

3. Issuers should use as many rows as necessary to accurately reflect the health benefit plan design.

4. Under the "*You will pay…."* column(s), issuers should include the cost sharing for both retail and mail order, as applicable.

5. Issuers may, at their option, add a row for mail order prescription drugs if the additional row helps to provide greater clarity to consumers as to the benefit.

F. Common Medical Event 4 – 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, Exceptions and Other Important Information* column. Significance of such expenses is determined by the

issuer based on two factors: historically high utilization and financial impact on the insured. For example, an issuer might show that the cost sharing for the physician/surgeon fee row is "20% coinsurance", but the *Limitations, Exceptions and Other Important Information* column might show "50% coinsurance for radiology."

G. Common Medical Event 5 – If you need immediate medical attention

No specific instructions for this event. Refer to Overarching Instructions.

H. Common Medical Event 6 – If you have a hospital stay

1. If there are significant expenses associated with a typical hospital stay that have higher cost sharing than the facility fee or physician/surgeon fee, or are not covered, then that must be shown under the *Limitations, Exceptions and Other Important Information* column. Significance of such expenses is determined by the issuer based on two factors: historically high utilization and financial impact on the insured. For example, an issuer might show that the cost sharing for the facility fee row is "20% coinsurance", but the *Limitations, Exceptions and Other Important Information* column might show "50% coinsurance for anesthesia."

I. Common Medical Event 7 – If you need mental/ behavioral health or substance abuse services

1. If the cost sharing differs for outpatient services for mental/behavioral health services or substance abuse services depending on whether the services are office visits or are other outpatient services, show the cost sharing for each. For example, an issuer might show that the cost sharing for Mental/Behavioral health outpatient services is "$35 copayment/office visit and 20% coinsurance /other outpatient services."

J. Common Medical Event 8 – If you are pregnant

1. If applicable, issuers should include an explanation in the *Limitations, Exceptions and Other Important Information* column that describes that the cost-sharing amounts listed may not apply to some services. The issuer should determine which, if any, of the following sentences to include in the *Limitations, Exceptions and Other Important Information* column: "No cost sharing for preventive services." "Depending on the type of services, a [copayment, coinsurance or deductible] may apply." "Maternity care may include tests and services described elsewhere in the SBC ([ultrasound, specialist services, etc.])."

K. Common Medical Event 9 – If you need help recovering or have other special health needs

1. Physical Therapy, Occupational Therapy and Speech Therapy services must be listed in the *Limitations, Exceptions and Other Important Information* column for the Rehabilitation services and Habilitation services rows.
2. If there is a quantitative limit (e.g., number of days, hours, visits covered) applicable to that service, those limits must be specified.

3. If the service is not covered, then the issuer should include the statement, "Not covered."

L. Common Medical Event 10 – If your child needs dental or eye care

No specific instructions for this event. Refer to Overarching Instructions.

V. GENERAL INFORMATION

The *General Information about this Plan, Grievances and Appeals,* Minimum Essential Coverage/Minimum Value Standard, *Language Access* Services (if applicable), and *Coverage Examples* sections must always appear in the order shown.

A. *Excluded Services* (Services Your Plan Does Not Cover) and *Other Covered Services*

1. Each issuer must place all services listed below in either the *Excluded Services* box or the *Other Covered Services* box according to the policy provisions. The required list of services includes:

• Acupuncture	• Non-emergency care when traveling outside the U.S.
• Bariatric surgery	• Private-duty nursing
• Chiropractic care	• Routine eye care (adult)
• Cosmetic surgery	• Routine foot care
• Dental care (adult)	• Weight loss programs
• Hearing aids	• Long-term care
• Infertility treatments	

2. The 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 *Excluded Services* box. Issuers should **NOT** duplicate services that are already listed as excluded or 100% coinsurance in the *Limitations, Exclusions and Other Important Information* column of the Common Medical Events chart.

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

4. In lieu of summarizing coverage for items and services provided outside the United States, the 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.”

5. If the issuer provides limited coverage for any of the services listed in item 1 above, the limitation must be stated in the *Excluded Services* box or the *Other Benefits Covered* box but not both. For example if an issuer provides acupuncture in limited circumstances, the issuer could choose to include the prescribed statement in the *Excluded Services* box, as follows: “Acupuncture unless it’s prescribed by a physician for rehabilitation purposes.” Alternatively, the prescribed statement could be in the *Other Covered Services* box, as follows: “Acupuncture if it’s prescribed by a physician for rehabilitation purposes.”

6. For example, if an issuer excludes all of the services on the list above except Chiropractic services, and also showed exclusion of Cosmetic Surgery in the Common Medical Events chart, the *Other Covered Services* box would show "Chiropractic Care" and the *Excluded Services* box would show "Acupuncture, Bariatric Surgery, Cosmetic surgery, Dental care (Adult), 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."

7. If the issuer provides coverage for the diagnosis of infertility, but not the services that treat the infertility (e.g., IVF, prescription drugs, etc.), Infertility Treatment should be listed in the *Excluded Services* box.

8. FOR QUALIFIED HEALTH PLANS: For an SBC prepared for a qualified health plan (QHP) offered through a Marketplace, the issuer must reflect whether abortion services are covered. Qualified Health Plans that cover excepted and non-excepted abortion services must list "abortion" in the *Other Covered Services* box. Qualified Health Plans that exclude all abortions should list "abortion" in the *Excluded Services* box. Qualified Health Plans that cover only excepted abortions should list in the *Excluded Services* box "abortion (except in cases of rape, incest, or when the life of the mother is endangered)" and may also include a cross-reference to the policy document that more fully describes the exceptions.

    a. With respect to Multi-State Plans, the Office of Personnel Management may issue additional instructions. Multi-State Plan issuers are directed to comply with such instructions with respect to disclosure regarding coverage or exclusion of abortion services.

IMPORTANT NOTE TO CCIIO, DOL and IRS ("the Tri-Agencies"):

The Subgroup discussed the placement of a disclosure about coverage of abortion services. The Subgroup ultimately agreed to leave the disclosure as proposed in the NPRM. However, the Subgroup noted the difficulty consumers would have in comparing coverages between QHPs and non-QHPs as to this coverage. The Subgroup also noted the potential for all consumers, regardless of their personal beliefs, to want full transparency about the existence or non-existence of coverage of this specific service. The Subgroup discussed ways to address these concerns and identified two. First, the Tri-Agencies could consider modifying applicable regulations to make the disclosure requirement applicable to all plans and issuers. Alternatively, the Tri-Agencies could modify the proposed instructions to make it clear that non-QHPs may also provide the disclosures, where appropriate, as either an "Excluded Service" or "Other Covered Service." The last process would permit plans and issuers to comply with any state disclosure requirements.

B. YOUR RIGHTS: GRIEVANCES, APPEALS AND CONTINUATION OF COVERAGE

1. Issuers should include the following paragraph with no variation, directly following *Other Covered Services*:

    "There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a Grievance or Appeal. For more

information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or grievance for any reason to your plan. There are also agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies:"
[Insert agency contact information]

2. Issuers should insert the following agency contact information, as applicable, for the agencies that have oversight for the health benefit plan. A chart is suggested here but is not required. Issuers should not repeat any organization's or agency's contact information, but should note all the areas where each agency or organization can assist.

3. For example, the federal Office of Personnel Management has jurisdiction over Multi State Plans and should be listed for an MSP, but should not be listed for a health benefit plan that is not a Multi State Plan.

[State insurance department contact information]	Complaints Grievances Appeals External Review Continuation of Coverage
[Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html]	Complaints Grievances Appeals Continuation of Coverage
[State consumer assistance program, if other than state insurance department – provide state-specific contact information available from http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/]	Complaints Grievances Appeals Continuation of Coverage
[Office of Personnel Management Multi State Plan Program : https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/]	External Review
[Healthcare.gov www.HealthCare.gov or call 1-800-318-2596][state health insurance marketplace or SHOP]	Other coverage options

C. MINIMUM ESSENTIAL COVERAGE/MINIMUM VALUE STANDARD

The following questions and statements must appear, immediately following, YOUR RIGHTS: GRIEVANCES, AND APPEALS AND CONTINUATION OF COVERAGE and the issuer must provide the appropriate answer for each health benefit plan.

Does this plan provide Minimum Essential Coverage? [Yes/No]

If you don't have Minimum Essential Coverage, you'll have to pay a penalty unless you get an exemption from the requirement that you have health coverage.

Does this plan meet Minimum Value Standards? [Yes/No]

If yes, answer:
"This coverage provides a level of benefits specified in the Affordable Care Act as 'minimum value'."

If no, answer:
"This coverage does not provide a level of benefits specified in the Affordable Care Act as 'minimum value'."

D. LANGUAGE ACCESS SERVICES – taglines, culturally and linguistically appropriate requirements (if applicable):

1. In order to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, an issuer follows the rules in the claims and appeals regulations under PHS Act section 2719. 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.

VI. Coverage Examples: Calculating Cost Sharing

1. The items at the top of each coverage example stating the overall deductible and applicable copayment and coinsurance amounts should be the same as the in-network cost sharing amounts (or the applicable cost sharing amounts for non-network plan types) previously stated in the various sections of the SBC.

    a. Cost sharing for self-only coverage should be used.

    b. In addition, issuers that use networks, including tiered networks, should use the cost sharing from the most favorable network tier. For example, the overall deductible provided on page 2 should be repeated as the first bullet point for each coverage example. As another example, the specialist copayment amount for "Peg is Having a Baby" should be the amount stated in the left-most "*You will pay…*" column for Common Medical Event #8 – "Office Visits" for a tiered network health benefit plan.

    c. If any of the items are not applicable to the health benefit plan, issuers may state "N/A" for that item, or "none", or may use or "$0", or "0%" or other method for indicating the item is not applicable to that health benefit plan. Issuers are encouraged to use "N/A" or "none" for such items to the extent that it's technically feasible to use text instead of zeros.

2. The U.S. Department of Health and Human Services (HHS) will provide all issuers with standardized data to be utilized for in the Total Example Cost row for the coverage examples.

    a. HHS will also provide underlying detail that will allow issuers to calculate *Cost Sharing* amounts, including: Date of Service, medical coding information, Provider

Type, Category, descriptive Notes identifying the specific service provided, and Allowed Amounts.

b. All 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.

3. Each issuer must calculate cost sharing, using the detailed data provided by HHS, and populate the *Cost Sharing* fields.

   a. Dollar values are generally to be rounded off to the nearest round number in dollars in order to reinforce to consumers that numbers in the examples 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 Coverage Examples.

   b. 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 issuer must show "$1,750" and not "$1,800."

4. Services on the template provided by HHS are listed individually for classification and pricing purposes to calculate the amounts for the *Cost Sharing* section. HHS specifies the Category used to roll up detail costs into the categories listed above the "Total Example Cost" row. Some issuers may classify that service under another category and should reflect that difference accordingly. The issuer should apply their cost sharing and benefit features for each health benefit plan in order to complete the *Cost Sharing* section, but must leave the categories listed above the "Total Example Cost" row as is. Examples of categories that might differ between the *Cost Sharing* section and the categories listed above the "Total Example Cost" row could include, but are not limited to:

   a. Payment of services based on the location where they are provided (inpatient, outpatient, office, etc.)

   b. Payment of items as prescription drugs vs. medical equipment

5. Each issuer must calculate and populate the *Cost Sharing* section based upon the cost sharing and benefit features of the health benefit 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).

   a. Deductible(s) - includes everything the insured pays up to the deductible amount(s). Any copayments that accumulate toward the deductible(s) are accounted for in this cost sharing category, rather than under copayments.

   b. Copayment - those copayments that don't apply to the deductible(s).

c. Coinsurance - anything the insured pays above the deductible(s) that's not a copayment or non-covered service. This should be the same figure as the Total less the Deductible, Copayments and Excluded Services.

d. Excluded Services - anything the insured pays for non-covered services or services that exceed coverage limits.

6. If the issuer has a wellness program that varies the deductibles, copayments, coinsurance, or coverage for any of the services listed in a treatment scenario, the issuer must complete the calculations for that treatment scenario assuming that the patient is NOT participating in the wellness program.

7. If all of the costs associated with the Coverage Examples are excluded under the health benefit plan, then the entire "Total Example Cost" amount should also appear on the lines for "Excluded services" and "The total [Peg][Joe][Mia] would pay is:". The Cost Sharing lines should be left blank.

National Association of Insurance Commissioners & The Center for Insurance Policy and Research

MEMORANDUM

Date: October 6, 2015

To: Secretary Burwell, U.S. Department of Health & Human Services

Secretary Perez, U.S. Department of Labor

Secretary Lew, U.S. Department of the Treasury

From: Consumer Information (B) Subgroup and Advisory Working Group

Subject: Recommended Revisions to the Summary of Benefits and Coverage (SBC)

Overview

The Subgroup and Advisory Working Group (hereinafter collectively referred to as the Subgroup) appreciate the opportunity to review the Summary of Benefits and Coverage (SBC) and provide recommendations to the Tri-Agencies as to potential revisions. The Subgroup has been diligently and earnestly working since late spring and throughout the summer to develop recommended revisions to the SBC.

The Subgroup's objective was to review the SBC currently in use, and the revisions to the SBC in the Notice of Proposed Rule Making (NPRM) to identify areas where the SBC could be revised to improve the usability and effectiveness of the SBC for consumers. The Subgroup would then make revisions to the uniform template and subject those recommended revisions to consumer testing to determine their effectiveness. Finally, the Subgroup would make any further revisions to the uniform template based on the testing results.

To prepare for its review, the Subgroup heard from assisters, navigators, producers and employer representatives regarding their use of the SBC template currently in use. The Subgroup then undertook a deliberate and methodical review of the uniform template and corresponding instructions. Throughout the entire process, the Subgroup also received and considered comments from a variety of other interested stakeholders.

The Subgroup completed its initial work in mid-August. The NAIC engaged the firm Kleimann Communications Group, Inc. to conduct cognitive interview consumer testing. The Kleimann Communications Group had conducted consumer testing of the original coverage facts label and has

extensive experience with consumer testing of consumer disclosures, much of which is done on behalf of federal governmental agencies.

Following the testing, the Subgroup was provided a report of the results of the consumer testing. A copy of the report is included as a reference. The Subgroup then worked throughout September to incorporate many of the findings from that consumer testing as well as specific recommendations from the Kleimann Communications Group. Kleimann was again consulted regarding the final template the Subgroup completed. A copy of the communication outlining their review of the template is also provided as a reference to this memorandum.

Due to the extensive review process, the Subgroup has not been able to finalize its review and recommendations regarding the Uniform Glossary. The Subgroup has committed to finalizing its review and recommendations for submission to the Tri-Agencies by the end of the year.

Recommendations as to the Uniform SBC Template

Overarching recommendations

Page Limitation: 

The Subgroup struggled with many issues throughout its review. The most notable of which was the balance of providing accurate and clear disclosure within the page limitation, as that has been interpreted by the Tri-Agencies (4 sheet document with 8 sides). The Subgroup unanimously and strongly recommends the Tri-Agencies interpret the statutory page limitation as applying to the "uniform template" and not to an SBC after it has been completed or issued by a plan or issuer. The Subgroup's final recommendation is a 4 sheet document with 7 sides, which meets that specification.

The Subgroup believes any other interpretation would severely and unnecessarily restrict the amount and quality of information provided to consumers. The Subgroup further believes that interpreting the page limitation as applying to a completed SBC would be inconsistent with the stated purpose of the SBC, which is to "*accurately describe[s] the benefits and coverage under the applicable plan or coverage*".

Link to Uniform Glossary: 

The Subgroup strongly recommends the Tri-Agencies establish a "micro-site" for the terms contained in the Uniform Glossary. This would allow the SBC to electronically link directly to specific defined terms. Various consumer studies and the consumer testing of the SBC clearly show consumers prefer accessing information electronically. Consumer testing revealed consumers reluctantly would seek out additional information that was not easily accessible through electronic means. Alternatively or in addition to developing a "micro-site," the Tri-Agencies should consider embedding the SBC with "hover text," which would allow electronic users to place their cursor over defined terms to easily see the corresponding definition(s). Again, this recommendation is intended to give consumers better access to the information they need to utilize the SBC in an electronic medium, which they overwhelmingly prefer.

Reference Pricing:

The Subgroup discussed reference pricing where a provider accepts the reference price and is an in-network designated provider, while all other providers are either out of network or non-designated providers who can then balance bill the consumer the difference between the provider's charge and the reference price. The Subgroup is not aware that this is a widespread practice, and only knows of its use in a few large self-funded employer situations. However, guidance[1] issued by the DOL would permit more widespread use of reference pricing and in-network balance billing by large group and self-insured group health plans. The subgroup understands the Tri-Agencies are monitoring the issue of reference pricing. If the practice becomes more prevalent, the Tri-Agencies should consider whether a specific disclosure of these kinds of networks within the SBC is warranted.

Listing of recommended revisions

The following is a comprehensive listing of the significant and notable recommended revisions to the uniform SBC template, section by section.

Introductory Page 1

The uniform template now includes an introductory Page 1. This page was created specifically in response to consumer testing that revealed consumers were unable to articulate a purpose of the document and the former Page 1, which was the Important Questions section. (Kleimann Report p. 5) The Kleimann Group made a specific recommendation that the SBC should have a "clear visual scaffold" that would have a clearly stated purpose for the document and provide a "map" to the rest of the information (Kleimann Report pp. 25 – 27). The Subgroup feels the new Page 1 accomplishes these goals and confirmed that the revisions were in line with the recommendations by consulting with the Kleimann Group (Email dated 9-28-2015)

The Introductory page provides the visual scaffolding and map to the document. It also addresses other key areas. It tells consumers the premium information (which was identified as a piece of information important to consumers) will be provided to them separately. The page now also introduces consumers to key concepts they will see in the following pages and explains why those concepts and information is important for them to review.

Coverage Overview

The Coverage Overview section is what was previously referred to simply as "Important Questions". The Subgroup made no structural changes to the template. The Subgroup did add a new question about services that are covered before the deductible is met. The Subgroup also modified the question regarding the presence of networks in the health plans. This modification was due to the significant confusion revealed in consumer testing regarding plans with more than one network. The majority of revisions to this section are contained in the instructions where again the

[1] http://www.dol.gov/ebsa/faqs/faq-aca19.html

Subgroup attempted to clarify and streamline the responses plans and issuers will provide to consumers.

Common Medical Events

The Subgroup made limited structural changes to template for this section and some changes in terms of some of the services identified. Finally, the Subgroup also made changes to the instructions to provide additional information to consumers and to provide clarity to plans and issuers on completing the form.

A new overall warning box has been added as a result of reviewing consumer testing to reinforce that the co-payments and co-insurance amounts shown are imposed after any overall deductible amount has been met. This phrase can be modified for plans that have no overall deductible. In addition, this header box also reinforces how consumers can obtain a copy of the Uniform Glossary, an issue identified in the consumer testing.

Structurally, the template was modified in a couple of key areas. First, the label for the cost sharing columns was modified to "What You Will Pay". Plans and issuers are permitted to use the terms referring to network providers used in their coverage documents as the headers for the columns in which specific cost sharing information is portrayed. Consumer testing shows that this will reduce consumer confusion and will improve consumer understanding of cost sharing information. Use of the "you will pay the least," if necessary, "you will pay more," and "you will pay the most" language will minimize issues around not using standardized language describing the various coverage tiers or levels.

Second, the template was modified from having just Limitations and Exceptions to add Other Important Information.

As to the specific events and services, consumer testing clearly demonstrated that consumers struggle with obtaining information on prescription drug coverage and consistently missed information on where they can find additional information when it was contained in the first column. The Subgroup strongly believes putting the information on obtaining the information as a separate colored or shaded row, as reflected in its recommendation, is a preferable solution to this issue.

In addition, the Subgroup believes plans and issuers must be given the ability to complete the SBC using the prescription drug coverage terminology utilized within coverage documents. While this may appear to reduce standardized SBC language, the Subgroup believes it is far more important that plans and issuers utilize their language so that instances of consumer confusion is reduced when consumers need to consult plan formularies for information related to a specific drug. As with the provider network issues, use of supportive language like "you will pay less of the cost," or "you will pay more of the cost" will minimize issues around not using standardized language describing the various coverage tiers.

Rows have been combined within the mental health, behavioral health or substance abuse services common medical event, as these services are treated in the same manner with the only determining factor being an inpatient or outpatient setting.

The pregnancy common medical event has been altered by the addition of a third row and revising the existing rows. Following in-depth discussions, the Subgroup came to the conclusion that the current and NPRM language mixed pre-natal and post-natal information in the various rows that should be disclosed separately. By creating a third row the Subgroup believes these services can more clearly be portrayed.

The instructions for the common medical event for help recovering or special needs, and specifically for rehabilitative and habilitative services, has been modified to provide specific clarity to consumers as to the various types of services that will be covered and limits that will apply to each. For example, plans and issuers will have to disclose the coverage of occupational therapy, physical therapy, speech therapy and the limits which may apply to each.

General Information

Consumer testing clearly identified the excluded services, other covered services, grievances and appeals, MEC and MV standards and language access services sections need to be better organized to provide sufficient structure so that readers can understand their importance and not skip over the information. As a result, these sections have been provided headings and presented in a manner to further assist consumers in understanding the information portrayed.

One outstanding issue was discussed at length by the Subgroup, however, and no consensus recommendation was reached. That issue is with regard to the top 15 foreign language tag lines for each state. Consumer advocates strongly believe the SBC information should be provided to as many populations as possible in their native language. The issuers strongly assert that the 2016 Payment and Benefits Rule (subregulatory guidance for QHPs) does not provide sufficient guidance and, in fact, conflicts with the adopted SBC final rule. Regulators expressed concern regarding the applicability of the requirement to only QHPs – arguably, a limited population – and is a move away from uniformity. In addition, regulators expressed strong concerns about a significant regulatory requirement that has not been formally promulgated. In the end, the Subgroup leaves this issue to the Tri-Agencies to determine the appropriate course of action and urges the Tri-Agencies to consider all of the concerns identified herein.

Coverage Examples

The most significant discussion, focus and resulting revisions the Subgroup recommends, outside of the creation of the Introductory Page, is to the Coverage Examples.

The consumer testing revealed a number of issues with the Coverage Examples as contemplated in the NPRM. Consumer testing showed low literacy participants focused on the specific cost detail by service in the NPRM. Kleimann noted in their analysis that while that focus on detail would

appear to be positive, it actually reveals a fundamental flaw in the NPRM Coverage Example. Participants "failed to synthesize the information into a meaningful understanding of what was being presented." (Kleimann Report, p. 25)

Kleimann stated the focus was an indication that lower literacy participants were "latching onto something that seemed concrete and controllable --- numbers". Consumers believed – despite all the admonitions and warnings – the cost information was real and indicated it helped them understand the cost of those services. NAIC staff and members who observed the testing process concurred that consumers fixated on the detailed cost information. In Kleimann's view, that level of specific cost detail "served as a distraction from being able to understand how this particular plan's deductibles, copayments, and coinsurance function in a particular scenario." The result of that distraction was the numbers became a proxy for understanding how that health plan would work for them and "that became the story the document was telling" them. (Kleimann Report, p. 25, pp. 20 – 24)

As a result, the Subgroup considered and is recommending significant changes to the Coverage Examples. Overall, these revisions can be categorized as simplifying and refocusing consumers to the most important information. The Subgroup strongly believes the focus of the revised Coverage Examples should be on "Understanding How This Plan Works" in terms of the cost sharing and out of pocket expense and **not** on the cost of health care services.

The revised Coverage Example hits other points highlighted in consumer testing. Consumers want the math to work. When the math in the examples doesn't work, that is yet another distraction that takes consumers away from – and, in fact, discourages them – from relying on the information. The Kleimann Group also recommended that the examples more closely follow or align with the information presented in the Common Medical Events. That recommendation is directly reflected in the middle section, where the services are ones that are listed in the Common Medical Events.

Conclusion

As it was asked to do, the Subgroup has carefully reviewed the SBC. It has discussed every aspect of the template and the corresponding instructions. The Subgroup considered interested stakeholder comments and heard directly from users of the SBC. The NAIC has funded consumer testing of the SBC and has received a final report outlining the results of that testing. Consumer testing is invaluable in determining not only how a document performs but also in clearly identifying what consumers themselves believe to be important information they need.

The Subgroup has thoughtfully considered all of this information, which has culminated in the attached recommendation. The attached recommendation reflects meaningful and substantial improvements to the SBC document and the Subgroup believes these revisions will directly benefit consumers. The Subgroup requests the Tri-Agencies adopt the revisions it has recommended.

While the Subgroup believes the recommended revisions it is submitting to the Tri-Agencies are necessary and important revisions which will benefit consumers, the Subgroup realizes that

consumer needs and health benefit plan designs are not static. Those can and will evolve over time. The Subgroup encourages the Tri-Agencies to view the SBC as a living and breathing document that should evolve over time to meet consumer needs and expectations.

The Subgroup would ask the Tri-Agencies to allow the Subgroup to undertake additional reviews and discussions regarding any future revisions to the SBC. Again the Subgroup believes its final work product reflects an open and deliberative review from a variety of stakeholders, and has been consumer tested. The Subgroup would ask that the Tri-Agencies consult with the NAIC prior to any future requests so the timing of such reviews is coordinated and allows sufficient time for a thoughtful and deliberative process, in addition to consumer testing.

The Subgroup once again thanks the Tri-Agencies for allowing it the opportunity to review and submit its recommendations.

CC: Commissioner Roger A. Sevigny, Chair, Health Insurance and Managed Care (B) Committee

Attachments:

Final Revised SBC Template
Final Individual Market Instructions
Final Group Market Instructions
Final Report: Consumer testing of a revised Summary of Benefits and Coverage Form and Uniform Glossary, September 22, 2015, Kleimann Communication Group, Inc.
Email Communication from Kleimann Communication Group, dated September 28, 2015

Final Report:

Consumer testing of a revised Summary of Benefits and Coverage Form and Uniform Glossary

Presented to
NAIC
September 22, 2015

Kleimann Communication Group, Inc.

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Introduction

Background

On December 30, 2014, the Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") published a notice of proposed rulemaking, including a new set of proposed Summary of Benefits and Coverage (SBC) templates, instructions, an updated uniform glossary, and other materials without consulting with the National Association of Insurance Commissioners (NAIC) or other interested parties.[1] On March 30, 2015, the Departments issued an additional Frequently Asked Question (FAQ) regarding implementation of the Affordable Care Act and agreed to wait for input from the NAIC and other interested parties, including consumer testing, before finalizing the rule. The Departments have stated that they need NAIC's final recommendations by the first week of September in order to incorporate its feedback and suggestions. In order to provide recommendations, the NAIC convened the Consumer Information (B) Subgroup of the NAIC to recommend revisions to the SBC and Uniform Glossary.

The Departments and NAIC's Subgroup both recognize consumer testing as important to ensuring that any revisions to the SBC and Uniform Glossary truly benefit consumers and do not reflect only what state regulators and interested parties presume will benefit consumers. For the original SBC, the NAIC convened a similar working group comprised of state regulators and a diverse group of stakeholders to develop a summary of benefits and coverage document and uniform glossary. Prior to being finalized by the Subgroup, the original SBC went through consumer testing funded by Consumer's Union and America's Health Insurance Plans.[2] Using these results, the Subgroup modified the SBC based on consumer performance.

For the proposed SBC, the Departments were willing to undertake their own consumer testing, but could not ensure that comments would be made public to show the reasoning behind the changes. Additionally, all suggestions by NAIC and interested parties needed to be received by July 1. Alternatively, the Departments were willing for NAIC to undertake its own testing and

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[1] The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories (the chief regulator, and their staff, from each state or territory is known as a member).

[2] See *Focus Group Summary, May 2011*, America's Health Insurance Plans, Blue Cross Blue Shield Association, and *Memo Report, June 3, 2011*, Lynn Quincy, Consumers Union, and Susan Kleimann, Kleimann Communication Group.

submit recommendations by early September. Therefore, NAIC decided to undertake its own testing to provide performance-based recommendations.

Previous research showed that the original SBC helped participants understand insurance concepts and compare health plans.[3] That is not to say that the SBC was without problems – for example, some participants had difficulty with terms, such as coinsurance, out of pocket expense, and deductibles. As part of its current revision, the NAIC working group has interviewed various users of the SBC. At least one interviewee confirmed that low literacy users, especially those with low health literacy, found the SBC useful in better understanding the often confusing world of health insurance.[4] Other interviewees, often working at larger companies, suggested that they did not use the SBC or that their employees did not find the coverage examples useful since they were too general and did not apply to them specifically.[5]

Recent consumer testing of the proposed SBC by the Center for Consumer Information & Insurance Oversight (CCIIO) again confirmed that the SBC made it easier to understand and easier to compare plans. However the CCIIO report also listed a number of issues, including that the SBC had too many large blocks of copy that were difficult to read and comprehend. Consumers also failed to understand a number of basic insurance terms, such as coinsurance, out of pocket limits and deductible.[6]

In short, these results suggested that further testing was warranted to confirm that the changes recommended by NAIC:

- help consumers compare two or more insurance plans; and
- enhance consumers' ability to understand language and concepts that inform choice.

Project Goals

The qualitative research goals for this project were quite specific for both the consumers and for the NAIC. For consumers, the goal is to (1) understand insurance concepts, (2) use that understanding to compare plans, and (3) choose a plan based on that understanding. For the NAIC, the goal was to understand the barriers to consumers being able to accomplish those three tasks.

Understanding that the SBC and Glossary are more than just "educational" documents, we specifically created a testing plan to capture and document the higher level thinking skills required

[3] See *Focus Group Summary, May 2011* and *Memo Report, June 3, 2011*.

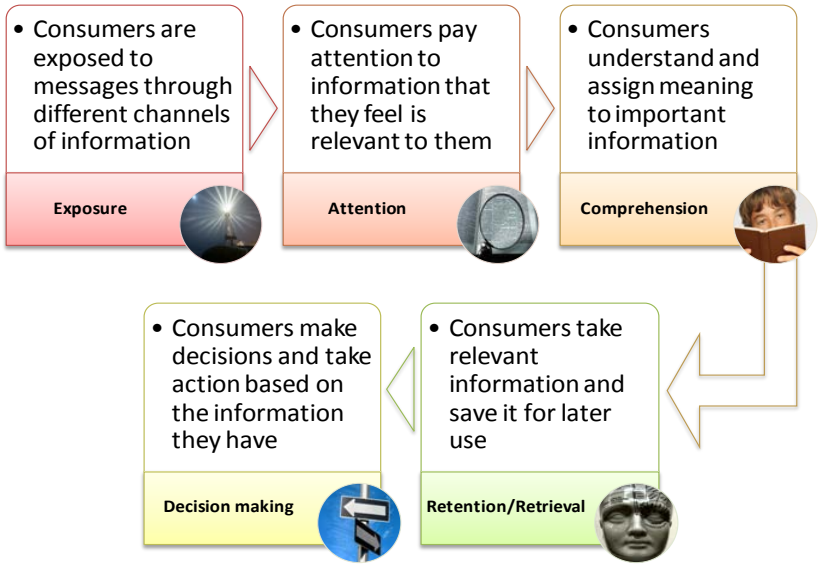
[4] NAIC, Conference Call Summary, May 12, 2015, Ms.Whitney Griggs, Georgians for a Healthy Future.

[5] NAIC, Conference Call Summary, May 8, 2015, Ms.Mary Amundsen, Bukaty Agency.

[6] Summary of CMS testing results, Memo from Ms. Mary Mealer, May 27, 2015.

to understand, compare, and choose.[7] Consumers need to not only find information in the SBC, but to actually *choose* a plan. Therefore, consumers must understand the concepts, synthesize the information, make tradeoffs cross elements of the plans (such as higher deductibles versus lower co-pays), weigh their personal situation, and then evaluate the options against one another.

Research shows that consumers go through a series of predictable stages when they encounter information: exposure, awareness, comprehension, retention/retrieval, and decision making.[8] As we collected information from consumers, we wanted to consider how consumers acquire and process information, a process illustrated in Figure 2, below.[9] Any individual can be at any point on this continuum.



For this project, we considered how individuals viewed the SBC, how easily they judged the "relevance" of the information, what information they felt was important, what kinds of tradeoffs they made, and whether they could use this information to actually make a decision about a plan. See *Methodology and Demographics* for more information about our testing methods.

[7] Bloom's taxonomy shows the increasingly complex cognitive skills, such as evaluation and synthesis, required to compare and make choices across comparisons. See http://www.nwlink.com/~donclark/hrd/bloom.html

[8] McGuire, William J. (1976). "Some Internal Psychological Factors Influencing Consumer Choice," *Journal of Consumer Research* 2 (March), 302–19.

[9] Based on McGuire, William J. (1976). "Some Internal Psychological Factors Influencing Consumer Choice," *Journal of Consumer Research 2* (March), 302–19.

Findings Pages 1-2

Participants could not clearly articulate the purpose of pages 1-2

Nearly all participants immediately responded positively to these opening pages. They commented on liking the table and the way information was organized so that it was easy to see and follow. They noticed the headings of *Important Questions*, *Answers*, and *Why This Matters* and felt that these headings were useful. They were even pleased to see topics like 'deductible' and "referrals" covered.

However, when we asked participants to tell us the purpose of pages 1 and 2, nearly all stumbled as they tried to articulate it. A few had seen the "alert sign" at the top of page 1 and would note the language saying these pages were "a summary" of the plan. Others looked at the items and stated that the pages seemed to describe the "upfront costs" of the plan. Very few were able to tie together the logic of grouping deductibles, out-of-pocket limits, networks, and referrals into one section.

Perhaps more importantly, their inability to articulate a purpose suggests that the opening pages of the document served neither to set up the intended purpose of the SBA as a whole nor an apparent purpose for the information on this page.

> *This is just the summary…so it says that you pay these amounts before the plan begins...so it just gives the amount that you would pay but not necessarily like, over time or how long you would have to...you know what I mean? Like, if you can pay it in increments before the plan initiates is how I read it. I don't know. (Baltimore English 5)*

> *I am seeing thousands and not understanding the page. The first page can get me lost. Why am I paying $4000 or $10,000? What is network? Then if you go through it [pages 3-9], it is breaking it down. That is why you are getting these numbers. (Baltimore English 2)*

> *They're kind of giving you a broad overview of what the plan does in relation to your portion of what you're paying for services and what portion the insurance plan is going to pay. So it tries to spell out some common procedures and you know, illnesses and services that are a little bit more common than what your point of payment would be for that service, what you could be liable for after the service has been provided. (Kansas City English 3)*

RECOMMENDATIONS

- Reconsider whether this section belongs here in this format
- If it does, then add a statement of purpose that explains why this information is important or what the unifying logic of supplying this particular array of information
- Use a heading that is more descriptive than *Important Questions*

Some thought the most basic fact was missing – premium amount

For many participants, the premium amount is the most basic fact around a health plan. It is what the plan costs you, even if you never use any other service. As a result, in a document that from the first page, includes dollar amounts, many participants expected to see this key cost fact. When we asked them if they would be interested in this particular health plan, some stated they couldn't choose a health plan without this key cost fact. Others wondered why the premium or monthly amount would be omitted.

Some participants considered the premium so basic that they looked for a number to be the "premium." These participants assumed the "deductible" would be their premium amount or the "monthly amount" they would pay because it would be deducted from their paycheck.

With premium such a basic concept to insurance, it needs to be addressed in some way. Because the document is intended to be a "Summary of Benefits and Coverage", information about the premium doesn't technically belong here. However, because participants/consumers have such a strong expectation that it will be present, it may be useful to meet their needs to avoid confusion. Again, a strong statement of purpose for the document will also help to shape expectations about the kind of information that will be included.

> *In my opinion I need to know how much they are going to pay and how much I have to pay. Maybe this is simple. Maybe to somebody…I really truly did not read the whole pamphlet when I got my insurance. I just needed to know how much was coming out of my check and what was covered and what was not covered. (Baltimore English 1)*
>
> ***So by what it cost, you mean you don't see the premium?*** *Exactly. These are my first questions that come into my mind. (Baltimore ESL 2)*
>
> *You know, I would have probably have liked to have seen the monthly premium in one of these pages because yes, the deductible is important. It is because that's what most directly affects you. But you know, when I see these deductibles, I immediately want to know, what is*

my monthly premium going to be and how that factors in on whether or not that deductible is...you know, going to be right for me and going to be affordable for me. (Kansas City English 3)

RECOMMENDATIONS

- Include a place for the premium amount or a simple sentence that refers them to where they can find the premium amount.
- If not possible, include a Q&A that explains why the premium is not included to avoid confusion since so many participants expect it to be included.
- Include a strong statement of purpose about the document at the start of page 1 to shape expectations about the type of information that will be included. 

Participants found the key term "network" confusing and undefined

Throughout these two pages, the terms "designated network," "network," "non-network," and "tiers of network providers" are used in four of the seven questions and answers. So, to understand the information in this section, understanding the difference across the terms is essential. Participants had some basic familiarity with the idea of a network and being "in-network" or "out-of-network." But nearly all were confused by the terms "designated network" and "tiers of network providers." Some participants looked for definitions on the page but found none. Others turned to the *Glossary*, but only the generic term "network" is defined in the *Glossary*.

As a result, participants had to read a page that is marked as having *Important Questions* but they could not assimilate the information fully because they were missing the definition of a key term. In addition, they encountered sentences in *Why This Matters* such as "You will pay more if you use a non-network provider or providers not in the 'designated network'. Be aware, your 'designated network' or 'network' provider may use a non-network provider for some services (such as lab work)." In this sentence, nearly one-third of the words or phrases are "network," "provider," "designated network," or some variation. As such, these sentences are practically impossible to read with comprehension.

Once again, the opening two pages failed to orient the participants to key concepts and terms that were fundamental to understanding the information on this page and to subsequent pages as well. If these pages are raising *Important Questions*, they cannot introduce terms that are so central to understanding and still leave them undefined.

And I'd just be interested to know what the different levels are, level one, level two, level three, designated network provider...the difference between the designated network provider and the network provider. Those both sound similar to me. (Kansas City ESL 3)

I'm looking for designated network [in the Glossary], I don't see designated network. Here is out of network, not really. It doesn't tell you what the designated network is, it just tells you what network is. It doesn't say non-network, it just says non-preferred… Tiers of network providers, I don't know what that means, tiers of network providers. (Baltimore English 2)

It would be nice to have a breakdown of what a non-network service is considered...what is considered a non-network service? (Baltimore English 5)

RECOMMENDATION

- Define the variations of network.
- Rewrite p.2, second row, *Why This Matters.*

Participants were confused by numbers separated by a slash

Very few participants knew how to read the numbers that were separated by a slash. Most participants thought that the numbers, such as "$1,000/$2,500 designated network", represented a range that they would need to meet for their deductible, perhaps dependent upon the plan they selected. Some participants said that the first number referred to what they would pay and the second number referred to what a family member would pay. Some thought each family member would need to meet a deductible amount equal to the second number, for example, $2,500 for the spouse and $2,500 for each child; some thought the family members together had to meet a deductible amount equal to the second number, for example, $2,500 total for the spouse and all children. Participants had the same kinds of difficulty interpreting the slashed numbers with "out-of-pocket limits", not knowing if they were looking at a range or at an individual and a family cost.

In Kansas City, a few participants with higher insurance literacy thought the deductible could not be identified until the plan premium was chosen and didn't understand why these numbers were being given at all.

Again, the numbers on these pages are intended to give readers information and yet unintentionally provide mis-information at best.

I look at the coverage criterion. I see the deductible and I know that is important. My question is, is this deductible per person or per family? (Kansas City English 2)

$4,000 and $10,000. I'm assuming it's individual, family, the two numbers. (Baltimore English 4)

RECOMMENDATION

- Identify what the numbers refer to either parenthetically $1,000 (individual) - $2,500 (required of each family member or a total for all family members) or a range of $1,000-$2,500 depending on your premium.
- Explain how a deductible is being able to be shown.

Out-of-pocket limits challenged most participants

Because of the slashed numbers (as mentioned above), participants entered this section with an immediate lack of clarity or a misunderstanding in terms of what those numbers referred to. So while they could understand the usefulness of knowing the limit in the abstract, they did not know it in the concrete because they did not understand the slashed number. When they turned to page 2, they read the long list of what is not included in out-of-pocket limit; however, many of these terms are terms that participants traditionally have difficulty understanding, such as copayments and coinsurance. Although some participants did go to the glossary to look for definitions, a few understood the definitions and some still did not. In all cases, the movement took them away from the text and understanding the text.

Interestingly, providing what is NOT included is one way people understand a meaning. The other way is to tell them what IS included. With a sense of what is and is not included, many people can come to a better sense of the meaning. So in this instance, with only a listing of what is not included, few participants could determine what counted toward the out-of-pocket limits.

What I am not getting is the out-of-pocket. Is that my pocket or the insurance pocket? (Baltimore English 1)

I'm looking at page 2, what is not included in the out-of-pocket limit, so premiums, balance bill charges...I'm not sure what balance bill charges are. Deductibles on certain services and healthcare this plan doesn't cover, that's also a little bit off-putting because I don't know what those are. (Kansas City ESL 3)

RECOMMENDATIONS

- Clarify what the slashed numbers refer to in terms of the limits with individuals and families.
- Add a Q & A to page 2 that explains what contributes to reaching the out-of-pocket limit

- Place this new question before what does not contribute.

Most participants see “referral” information, but “prior authorization” may need to be included as well

Some made positive comments about the plan when they saw the referral information on page 2. It was clear that they understood that this was a benefit and something that would influence their decision about choosing a plan.

Interestingly, at least one person in Baltimore, while reading pgs. 3-10, commented on each “preauthorization” as a kind of needed “referral.” She talked about “preauthorization” as being similar to a referral because a person had to approve a medical action before you took the action or your insurance could change what it would pay. Because these both had a financial consequence to the consumer, she grouped them. For the purposes of informing consumers about financial consequences, it may be worthwhile to point out that preauthorization is a characteristic of a plan.

> *I’m wondering if they're trying to change the wording for referral and authorization because again they're using authorization here. Prior to reading this, it said about the whole referral. So I don’t know if they're trying to like just use another word for referral. (Baltimore English 1)*

RECOMMENDATION

- Add a question to page 2: Does this plan require preauthorization?

Findings Pages 3-10

Most saw the purpose of pages 3-10 as providing "the cost of using my plan"

Participants, for the most part, could scroll through this section and overall capture the gist of these sections, especially those on pages 3-9. They also liked the format and read the headers, so understood that they were going to see a list of *Common Medical Events* and then details about each event. They did have more difficult with pages 10 and 11—which we cover later. Even when some details or definitions were unclear, participants still understood what the overall idea was behind the presentation of information.

However, few, if any, participants identified the underlying logic for the ordering of the information. In fact, for many, the list of events became a blur of one detail after another that they simply scrolled through, sometimes looking for an event that interested them, such as pregnancy or mental health services. Without a statement that explains the order, the cognitive burden of the information increases sharply. Participants encounter details without knowing how to fit these into a larger pattern. They are simply pieces of information. Participants looking for a particular service have no way of finding the service except to scroll through all the pages. The addition of some sort of shaping statement allows consumers to see a larger picture and provides a context for the details and a means of accessing specific details.

> *I mean like it breaks down what your services are. And it breaks down what your co-pays are and a little bit more information as to what exactly you're qualified to pay…I mean basically…I kind of want to say an itemized type of thing. So this breaks it down more to you say, okay, your $25 is going to x-rays and your visits to the doctor. So it breaks it down as to…for you to know exactly where your money is going to as opposed to an overall type of thing. (Baltimore English 1)*

> *I mean, it's information about how your...benefits work out, what you have to pay, what your expenses would be with this. (Baltimore English 6)*

> *It is breaking down what your individual event is going to cost you. (Baltimore English7)*

RECOMMENDATION

- Add a statement that explains why the events are placed in the order that they are.

The basic chart heading “Levels 1, 2, 3” were misunderstood by most

Participants encountered great difficulty understanding Levels 1, 2, and 3. Although participants knew the levels were different, they usually did not understand that these were actually connected to the concept of network, designated network or out of network. Often, they assumed that the levels were different plan options or that they denoted a choice that they needed to make before being enrolled in the plan. Further, many assumed Level 1 was “better” because it cost more, but only a few could articulate what the difference was.

Most participants could not connect the discussion of “tiers” in the opening pages with the levels on pgs. 3-9. This misunderstanding is likely due to the fact that the document uses two different sets of terms (“tiers” and “levels”) to refer to the same concept. When consumers encounter different words, they typically expect that they are also dealing with different concepts. Consistent wording helps mitigate such misunderstandings.

> *Levels 1, 2, and 3, like what’s the difference of each level? Does it mean that one specialist or one network is better than the other? That’s unclear. (Baltimore ESL 1)*
>
> *I don’t [know the difference in the levels] but I could take a guess. I would imagine that Level 3 would be seeing the doctor, being diagnosed, and getting rid of the problem. Is that what it is? (Baltimore English 1)*
>
> *I would think about whatever tier, level that I would choose. It jumps from five to 25 dollars depending on the level that you choose so at this point I couldn’t help but wonder why what you’re lacking pretty much if you chose the less level, level one as compared to level three because of the way that it jumps from 5 dollars to 25 dollars. (Kansas City English 1)*
>
> *I think I need to understand Level One, Level Two, and Level Three better. Services Provided by a Non-Network Physician in a Designated Network; a Designated Network or a Network Facility. However, you will be responsible to the Non-Network Physicians. This is very confusing. I understand it, but the normal person reading through that would be like, what? (Kansas City English 2)*

RECOMMENDATION

- Define “levels” early in the document when discussing network, designated network, out out of network. This will provide a cognitive scaffolding for readers when they get to later pages.
- Don’t use “tier” and “level” to refer to the same concept. Select one and use consistently.

Many participants were unfamiliar with key insurance terminology

In general, participants misunderstood key terms provided in the document. Some of this misunderstanding is due to low health literacy or basic literacy. Many terms are simply not familiar to the average person and are not used in everyday conversation (e.g. “habilitation”).

Participants thought they understood what a word meant, but often provided a very different definition than the correct one. One example is “coinsurance.” Participants often guessed at what this term meant, often interpreting it as having “two” insurances (primary and supplemental) with the supplemental coming in to pay 20% after the primary had paid 80%. Obviously this is an incorrect interpretation.

Finally, participants struggled with highly specific ACA terms such as minimum essential coverage, minimum value standard, and premium tax credit. They seemed to simply skip over these terms and ignore them.

Key problem terms throughout the document include:

- Coinsurance
- Copayment
- Cost sharing
- Deductible
- Designated network
- Habilitation
- Minimum essential coverage
- Minimum value standard
- Non-scheduled admission
- Out-of-pocket
- Premium tax credit
- Skilled nursing care
- Specialty drugs

Everything is slotted and everything is pretty much easy to understand. The way that it's broken down. But the thing is, is that some of the terms, that's what I think, some of the terms are not as easy to understand. (Kansas City English 1)

I'm going to go back to my other document and take a look at that (from glossary to pages 1-2). Deductible. Services covered before you meet your deductible. Out-of-pocket limits. Still trying to figure out exactly what a PPO is. It's telling me what's included but I just, for some reason I'm stuck on PPO and I wanted to know what that stands for. (Baltimore English 3)

I am looking at the glossary for the deductible information. So, it says, if your deductible is a $1000, your plan won't pay anything until you match a $1000 deductible to cover healthcare services. (Kansas City ESL 1)

When reading like the second row, I don't know what a coinsurance is. I don't know if it means the same as a copayment…I know that they try breaking it down. But to me it just seems a little…still a little too confusing. (Baltimore ESL 1)

Rehabilitation services versus habilitation services. I wonder what the difference is between rehabilitation and habilitation. Rehabilitation I'm thinking you're trying to get folks back to the way they used to be. Habilitation is that ... I don't know. That's a new one for me. I don't think I've really heard of habilitation services. (Baltimore English 3)

Specialty drugs are 20 percent coinsurance. I don't know what specialty drugs are. (Baltimore English 6)

Page 4, services you may need...tier three drugs, non-preferred brands. Again, I'm not sure what those are. Maybe if they were to...if they could list, you know, what common tier three drugs would be and what the difference between non-preferred brands and specialty drugs are. (Kansas City ESL 3)

RECOMMENDATION

- Consider defining key terms in the SBC – particularly coinsurance, copayments, and deductible, as these are key to understanding pages 3-10.
- Consider including references to the Glossary for difficult or unfamiliar terms.

The Glossary helped some participants with terminology

When participants encountered difficult and unfamiliar terms and questioned them, they were provided with a Glossary. The Glossary was met with various reactions from participants. Most

who used the Glossary felt it was helpful, particularly in explaining terms like coinsurance and deductible. In these cases, the scale visuals seemed to help explain the term.

However, some participants tried to use the glossary but could not find the terms. For example, several participants went looking for a definition of “Level 1, 2, 3,” but the Glossary does not use those terms.

A few participants looked up terms but could not understand the definitions provided. This issue seemed especially focused on ACA terms like “minimum value standard.”

Participants were mixed in reporting whether they would use the Glossary at home or not. Some felt it was extraordinarily helpful and reported that they would definitely use it. Others admitted that they would not use the glossary even if it were attached. A few said it would be easier or faster to simply Google the term.

> *This would help if I'm looking at this and I'm not in front of a computer that I can get on the website to access the glossary, this would help. I like the examples on here that kind of explain or give you an example, you know, the office visit was $100 and the med deductible...it would be 20% which would be $20, so you can kind of calculate that, and that would be good. (Kansas City ESL 3)*

> *I did [find the Glossary helpful]. As I went through the pages [of the Glossary], I could find what the out of pocket expense was even though I still would have had to call because I didn’t get it just yet. I think a glossary is always helpful in anything that you read. (Baltimore English 1)*

> *The glossary was very helpful. I think they did a reasonable job about giving you explanations and the limits, exceptions and other important information. Because even when I couldn't cipher what was here, I could go here to the glossary and figure it out. (Kansas City English 3)*

RECOMMENDATION

- Include the Glossary in any packet that participants get.
- Consider taking important definitions for commonly misunderstood words from the glossary and including them in the document itself (e.g., network, level, tiers, coinsurance)

Inconsistencies of presentation create confusion about visit limits

Participants commented on the different ways the limits on the number of visits is referred to in the sections on Mental Health Outpatient Services, Rehabilitation, and Habilitation Services on pgs. 6 – 9. For example some refer to a "maximum" while others refer to "per year" or "/year." These small inconsistencies raised questions in participants' minds. Some assumed the difference in presentation implied a difference in meaning, but couldn't figure what it was.

> *Physical therapy 40 visits per year. Occupational therapy, [inaudible] therapy 40 visits per year…Assuming it's 40 for each [family member] and not 40 for all of them together. (Baltimore English 4)*

> *The second one about the home health care, it says limited to 100 visits per year. So if I need…let's say if I have 101 visits, what happens after the 100 visits per year? Do I have to pay more?...So when they were breaking down about the visits for different types of therapy, and then they say here that the 40 per year visit maximum does not apply to those that have autism. What if I have a child that had a more severe disability and needs more than 40 visits for any of these therapies? (Baltimore ESL 1)*

> *$5.00 co-pay visit, $10.00 co-pay visit, $25.00 copay visit, but I would like to know if it would be $5.00 for the first 40 visits? (Baltimore ESL 2)*

> *I've never seen them put a limit on how many visits. That's interesting. Yeah, that's all not familiar; I've never seen where you had a limit on visits, certain visits. (Baltimore ESL 3)*

RECOMMENDATION

- Decide on a format for conveying limits of visits and apply it consistently in all cases, such as "Limit: 40 visits per year" or "40 visits per year maximum" or "40 visits/year."

Participants disliked groupings that continued onto next page

A small, but often cited, issue was that of the groupings of information. Participants would sometimes turn a page and be surprised or confused by a continuation of a category of information. They seemed to expect each category to be discrete and not break across pages. Others would want more information and ask about it, turn the page, and then say, "Oh, here it is." Although this issue did not provide major difficulties to participants, it does suggest that a cleaner format might be easier for consumers to use.

Again, I wish that they would have the whole childbirth and pregnancy all on one page. (Baltimore ESL 1)

RECOMMENDATION

- Arrange page breaks so groupings are on same page:
- Drugs, pgs. 3 -4
- Hospital stays, pgs. 5-6
- Pregnancy, pgs. 6-7
- Special health needs, pgs. 7-8

Many thought the *child dental and eye care* section was for adults

Most participants struggled with the child dental and eye care section. When they encountered this section, they did not read the heading "Child dental and eye care" in the left-hand column and, instead, went straight to the detailed information about coverage. They incorrectly misinterpreted the information as referring to adults as well – often expressing happiness and relief that they had this coverage. However, when participants got to page 10 and saw excluded coverage, they were surprised to read that dental and eye care services were not covered. Even when they read the words, they were unsure why it would apply only to children. As this is the only section that applies only to children, it needs special visual treatment to draw consumer attention to the difference.

This right here, it says if your child needs dental or eye care, is that just specifically for children? Or are you also referring to adults as well? (Baltimore ESL 1)

Routine eye care adult - dental care adult - these are services my plan does not cover. Then you go back here, page 9, and it says all of your child needs so you're telling me you won't cover it for me but you'll cover it for kids that I have? I don't like it. I don't like that at all. I'm just kind of mad that my plan does not cover dental care for me and routine eye care for me but it will cover it for the children that I apparently do not have. (Baltimore English 3)

OK. So this is only for a child. Dental or eye care. Not adults. OK…you know, not quite sure whether that covered everyone or not... I might have assumed it covered…it seems to be a family plan, cover the entire family not just children for eye care. (Kansas City English 4)

RECOMMENDATION

- Provide a visual marker – such as a break of white space, a heavier line, or an icon – to visually delineate that this section is different than the others and applies only to children.

Most found the organization and visual look of page 10 confusing

Page 10 was unclear to most participants. Although participants basically understood the idea of "additional covered" and "not covered", the presentation was confusing to them. Few understood why certain additional "covered" services were listed and wondered if these were the only additional covered services or just a list of the most important ones. They also questioned why "Not covered" services were placed first and, again, wondered if these were all of those not covered.

Finally, few participants understood that the remaining information (Additional Consumer Protections, Requirements of the Affordable Care Act, and Language Access Services) had any grouping, instead reading each line as a separate fact. A few participants felt this was "fine print" and didn't feel it was important or relevant to them.

> *Dental care is not included in your coverage. And a routine eye care is also not included. I think this is also a little bit unclear to me. Their coverage services. Does this mean that it's covered through the insurance or it's not covered through the insurance even though it doesn't say 'not.' But it's like right underneath where it says services your plan does not cover. (Baltimore English 1)*

> *I didn't see other coverage services. So it says it's not covered, but then under chiropractic it says 30 visits a year. So then I re-read that little thing that was in bold that says other coverage services, but why would it be… it looks like it's together with services that are not covered. So maybe it needs to be like a little bit more away from that, because it looks all lumped together kind of. (Baltimore English 4)*

RECOMMENDATIONS

- Redo layout of this page
  - Two side by side charts at top for Other Covered Services and Other Not-Covered Services
  - Explain why these items are included
- Add prominent headings to group remaining information, such as

- Additional Consumer Protections
- Requirements of the Affordable Care Act
- Language Access Services

Participants did not always know where to get more help

Many participants expressed interest in calling to get more information about the plan to help them decide if they would choose it. Unfortunately, participants often misunderstood who they should call based on the information presented. Most participants thought the 1-800 number at the bottom of the page was specifically affiliated with the health plan and readily said they would call this 1-800 to get more information about the plan. The prominence of the number (on the footer of every page) reinforced this misunderstanding. Unfortunately, if they did call this number, participants but would not get the assistance in learning more about the plan they sought as this is the HHS contact. Most participants missed the actual plan phone number on page 1.

> *I would call this number at the bottom. And it is at the bottom of each page, which is a good thing. (Kansas City English 2)*

> *Now these phone numbers that they have here, are these phone numbers to the actual insurance company or also to like the state type of thing? … And then also like if I was to call this number in Spanish, is it going to be someone that like an interpreter from a company that does not work at the health insurance that would not really give me much information as to the questions that I have about the health insurance? Is it going to be basically a third-party communicator? (Baltimore ESL 1)*

RECOMMENDATIONS

- Make it clear where participants can get more help via phone or Internet if they want/need it.
- Don't make the HHS number so prominent unless you want participants to call it to ask for specific health plan information.

Findings about Comparison Designs

Most participants found the comparison page helpful

After 10 pages of abstract information, most participants were grateful to have concrete examples and their general comments were supportive. No one suggested eliminating the *Coverage Examples* page.

Most participants found it useful to see how the plan would pay in three separate instances and most felt that the three examples used worked well, even if none of the examples related to them.

A few suggested alternate examples at extremes: a more common one of a doctor office visit or an urgent care visit or a more extreme example, such as treatment for breast cancer.

Nearly all assumed that the numbers used were tied to the specific plan and were disconcerted when told that the numbers were not. Nearly all participants understood that these were examples, not actual predictions of what their own personal costs would be. However a few participants did think these were similar to if not their exact costs.

> *I like the fact that they broke everything down. It seems more simpler in this format and more understanding. (Baltimore ESL 1)*
>
> *I think the page is actually trying to put into application the information it provided in the prior pages. I think it's trying to condense it in a format that's easier for people to understand. (Baltimore English 3)*
>
> *It is helpful...if you are planning a family, you can plan what it is going to cost you; what your hospital tab is going to be after insurance. Emergency room visits…it gives you an idea of percentages. It gives you a ballpark. (Baltimore English 6)*

Most participants preferred Alt 1 over Alt 2

Most participants thought that Alt 1 was "more informative" than Alt 2. They liked the additional detail of dollars that were provided under the sample care costs and the breakdown of those costs. Many seemed to feel more comfortable seeing the numbers, even the ones that might not matter to them (for example, how much the plan was paying for items like "anesthesia" during a delivery of a baby). It was as if the numbers pulled back a curtain on a mystery of costs for treatments—and they were delighted with this new information and knowledge.

Only a few high insurance literacy participants, however, saw this "new" information as irrelevant and distracting to the focus of the document on insurance costs. In fact, a few in Baltimore saw

the Cost of Care numbers as “advertising” to make you like the insurance company. To them, the focus should be on what the plan pays and what they pay and the other numbers were irrelevant.

> *Well you think you understand it more [ALT 1], because it’s telling you every step, the cost of care, it’s giving you that first, even if it’s only an estimate. (Baltimore ESL 2)*

> *Already this is clearer [ALT 1]. They did it as a math problem…They are telling you what everything costs. What’s covered, what’s not covered, and what your cost is. Right? It is much clearer. (Baltimore English 6)*

> *I like the detail and how it [ALT 1] breaks it down. Anybody who's ever been in the hospital or had to have a surgical procedure knows that it's not point of sale, like going to Best Buy to buy a VCR. Twenty years ago. DVD player or computer and then you make one payment, and that's it. Everybody knows, you get a bill from the anesthesiologist, get one from the ER, get one from the...but this at least gives you an idea of all the different aspects of having a baby and where those bills are going to come from…this helps you correlate where those costs are coming from and where those bills are coming from. (Kansas City ESL 1)*

> *It’s [Alt 1] more eye catching…This breakdown, it’s got the breakdown, some sample stuff of what it will cost you and once again I think that we as people like to see this whole breakdown. Oh wow I’m going to have to have this done, have that done. Oh it’s on here so that could possibly cost me this amount of money. (Kansas City English 1)*

Issues with Alt 1

Alt 1 was highly preferred among many participants who wanted to focus on the details. However, that focus revealed a number of issues with the numbers that should be addressed.

- The numbers don’t add up (the cost of care does not equal the cost the patient pays and the cost the plan pays).
- Some participants wanted more breakdown of the numbers – e.g., what comprises the $2680 copayment line? How many co-pays is that and for what?
- Some tried to match numbers to the co-payment and coinsurance amounts listed earlier and got confused when they didn’t match 1:1.
- A few low literacy or low health literacy participants thought these were exact costs, not examples.

See there is some sort of math here that confuses me…Let's go to the simple fracture. The cost of care is twenty four hundred dollars. The plan pays fifteen hundred dollars and I pay eleven twenty. That is twenty six twenty…Well I would hope that A plus B equals C and not D. I would expect if the plan is paying fifteen hundred then I should be paying nine hundred. The cost of care is twenty four hundred. (Kansas City English 4)

Why are your copayments that much unless they are equal in all the copayments from your doctor's visits? It looks like the $2860 should be a coinsurance and that was just the percentage of whatever…What exactly are the copayments? (Kansas City ESL 1)

I guess maybe this needs to show where this copayment number comes from. What makes up that fourteen one fifty times twenty percent, or whatever it is, so I can know what that is, and the same with my copayments all the way. (Kansas City English 2)

RECOMMENDATIONS

- Either explain why the numbers don't add up, or make them add up so it doesn't raise more questions.
- Make the coinsurance, copayment, and deductible numbers match in the Common Medical Events and the Coverage Examples.
- Explain where numbers come from – such as "this example assumes care for diabetes treatment for 1 year."
- Emphasize "sample" or "example" costs in the titles of the Coverage Examples section.

Some Baltimore participants preferred Alt 2, revised

In the original Alt 2 version shown only in Baltimore, participants skipped the basic cost-sharing information and had trouble linking the information in the first shaded box with the information in the second box. The second version, revised after Day 1 in Baltimore, used the cost-sharing information to create a scenario for the first box.

With the new Alt2, many Baltimore participants could state that the purpose was to explain how changes to the deductible affected the amount the patient pays. In addition, many participants were able to use Alt 2 to calculate different scenarios. For some participants, we changed the amount of the deductible and asked how much they would now pay as the patient. Many of the Baltimore participants could calculate accurately the new amount.

Many participants thought Alt 2 presented a more modern look and feel than Alt 1. Several participants commented positively on the graphical look, especially the use of the pictures. Even

those who preferred Alt 1 suggested that the Alt 2 pictures be added to Alt 1. Many commented on the modern look and feel of Alt 2, with its reliance on color-blocking and shading to separate information rather than lines, its graphical use of the numerals 1, 2, and 3, and the small photos.

A few participants who preferred Alt 1 suggested improving Alt 2 by adding some of the Cost of Care detail into this version.

> *Yes, it [ALT 2] was a lot of information, it looked nice and was very easy to snap right to it, so I was able to get the information and this is what it is talking about. It gave some information like your insurance pays eighty percent, you pay twenty percent and that was good information, but once it got down to the second box, I was like this isn't breaking out exactly as simple as this sheet did. (Baltimore English 7)*

> *Basically the cost of care, plan pays, patient pays on the second half, and the top part of this one which is deductible, copayment, coinsurance, so the raw information of the top half and the simple breakdown of the bottom. It is an example so I don't think they need to know sample of care costs. While it is good information, it is not necessary information. (Baltimore English 7)*

> *I like the pictures. I like this picture. I would like to have this picture better than the circles here. Example of the allowable amount, fantastic. Deductible, okay, excellent. This is excellent. I like the font size, it's easy to read. This is at 11, or something. If you could combine these two things into one, putting the pictures here, it makes it more clear for some reason. I like the fact that it says, do not use these examples below to estimate what you will pay, but everybody will anyhow. (Baltimore ESL 3)*

Issues with Alt 2

For all of the positive aspects of Alt 2, several problems emerged with this page.

- Most participants expected these Coverage Examples to be specific to the plan, especially if attached to the plan document.
- Deductible amounts don't match what participants remembered from earlier in the document.
- Participants, especially in Kansas City, wanted more numbers and calculations, not the words. These participants were particularly focused on numbers.
- Some participants didn't understand "allowed amount" and liked the "cost of care" better in Alt 1.

- The lower shaded box looks like a math problem, but isn't set up that way. For example, the minus signs in front of deductible and co-payment suggest subtraction, but we add those numbers together to find what the patient pays. Then we subtract what the patient pays from allowed amount to get what the plan pays. This is not intuitive.
- In the bottom two lines, bolding puts emphasis on what the plan pays; participants want emphasis on what they pay.

  I just think [ALT 2] is pretty generic. It tells you what you can anticipate what you are going to be billed for, and then; I think, like I said, if the copayments or if any of these in here have copayments with them, then it should reference back to that. It is just pretty generic. I think it is more confusing than helpful. (Kansas City English 2)

  I would not attach the generic to the plan unless it's plan-specific because I would assume that the example on the back applies to what you just showed me. (Baltimore English 4)

  And then [in ALT 2] different columns are having a baby, in-network emergency room visit, and in-network doctor visits, managing diabetes. So it's similar to that other page that we looked at, but it just looks like the other page is more plain, whereas this one has pictures on it, the bullets are a little bit bigger whereas this has like the versus deductible, copayment, and co-insurance. It just kind of looks different, the table. And then it doesn't go into as much detail as the other one as far as breaking down all the costs. (Kansas City English 3)

RECOMMENDATIONS

- Relocate the placement of this example. If this information is not specific to the plan, it needs to go elsewhere, perhaps in the Glossary.
- Set up the numbers so that they work as a calculation. Because of how the numbers were set up (stacked), participants expected to be able to do the math in a calculation.
- Continue to experiment with the scenario. Many participants did like aspects of this version and Alt 1 has a different set of problems. The revision to Alt 2 made in Baltimore after Day 1 improved the performance, but did not solve all of this version's problems.
- Consider adding some Cost of Care detail into this version, but only after deciding the focus of this page.

Observations

Low literacy participants want more information

The participants with lower literacy liked the entire summary, pages 1-12. They liked the opening two pages and they liked the detail in pages 3-9.Some even mentioned wanting more information than the 12 pages. When shown the two options for the *Coverage Examples*, nearly all of them selected Alt 1 because of the detail shown around *Cost of Care*. In fact, many were so focused on detail that they were willing to check the math in the examples to verify that the numbers added up. Some wanted even more information around these details, such as what comprised the total for the deductibles listed under *Having a baby*. Some went back to verify that information in the *SBC* matched the information in the *Coverage Examples*.

On the surface, this focus on detail would seem good; however, most of these participants failed to synthesize the information into a meaningful understanding of what was being presented. They could find, identify, and do low-level matching of information, functioning low on Bloom's taxonomy of cognitive skills. Their focus on the details seemed more a matter of latching onto something that seemed concrete and controllable—numbers; these could be added, subtracted, found, compared, and assessed as large or small. They allowed participants to comment on how this helped them understand what made a procedure or treatment have a particular cost. In this case, the details served as a distraction from being able to understand how this particular plan's deductibles, copayments, and coinsurance function in a particular scenario. The desire for details served as a proxy for having true understanding of how the health plan was functioning for them. For many of these low literacy participants, the detail became the story the document was telling.

High literacy participants want only key information

In contrast, participants with high literacy said the document had too much information. These participants wanted the basic information without all of what they considered distracting detail. It may seem counterintuitive that those who understand less, want more, and those who understand more, want less. However, it makes sense within the context of health literacy. Those who know more do not need detail to understand – they often already the basic mechanics of health insurance; they understand how premiums, deductibles, copays, and coinsurance work. With this contextual understanding in place, they don't want to have to hunt for the relevant numbers within additional explanatory information. They already know the story and want the document "get to the point" and understand how the information relates to them.

Some suggested just a table with information such as premium, deductible, copays, prescription drugs, and so on—what they considered basic information. While these participants found the

Coverage Examples helpful, they tended to prefer Alt 2 (with some caveats as noted above) because they saw the *Sample care costs* in Alt 1 as irrelevant detail to a discussion of insurance and more a promotion of insurance companies. For these high literacy participants, the detail was put into its proper place as **support** of the main story, not the main story.

Overall, there is too much information without salience

The material in the SBC is cognitively dense for any reader. It is filled with many concepts and many of them technical, complex, and unfamiliar concepts, such as coinsurance, copayments, deductibles, out-of-pocket limits, network and its variations. Even when people have heard the phrase or have a passing knowledge of a term like network, the SBC pushes them to understand "designated network" without providing a definition. So to process the information in the SBC, a consumer must first process a number of unfamiliar terms and concepts and THEN understand the context in which they are being used. This processing requires a high level of literacy to find, connect, and synthesize the information meaningfully.

Moreover, the presentation of information within the SBC seems to assume that everything is of the same importance. Although the first two pages are labeled *Important Questions,* the reader is not told why these are important nor even the overall purpose of the SBC. Without that overall cognitive scaffolding, the reader is being presented with detailed, complex information with no way to see the big picture or to distinguish one detail from another. In pages 3-9, there is a logic to the order of information, but the readers are not told what the logic is. They must spend cognitive energy figuring out these details without a frame in which to place them that helps assign meaning.

To compensate for all of this detail, several participants admitted that they would not read all of the SBC. Most said they would "skim it" and then call for help. We understand that the SBC is intended to be used within a social system of professional assistance, friends, and family. We would argue that this material is hard, but it doesn't need to be *this* hard.

RECOMMENDATIONS

- Provide a way for readers to find salience and why particular information is given to them
- Provide a clear visual scaffold
    - State why Part 1 exists. State how and why it is organized.
    - Be explicit about Part 2's order.
    - Mark the sections more clearly and more visually.

- State what is ‘critical to know’ from what is ‘okay to know.’
    - Put this information up front as a true summary.
    - Provide a map to the rest of the information.
- Focus on the key issue you want to illustrate in the examples. Participants like the concrete, but are distracted because extra information was included. Possible elements to emphasize include:
    - Why insurance is a good idea to have
    - What makes a procedure expensive or cost a particular amount
    - How a copay, coinsurance, deductible you owe affect what the insurance pays
    - How to weigh the various cost elements and make a decision

Methodology and Demographics

For this project, Kleimann used structured cognitive/usability interviews to collect data about how consumers used the SBC, Comparison Document, and Glossary to make decisions about a health plan. In this approach, we use a combination of a think-aloud protocol on the SBC and a series of objective questions.

- In the initial think-aloud portion of the testing session, the participant talked aloud about what he was thinking as he read through the SBC and one version of the Comparison Document (either Alt 1 or Alt 2) for the first time. This running monologue provided feedback based on what the participant noticed, but without questions on the part of the moderator. Think-alouds allow to hear the participants’ inner monologue while interacting with one SBC. We couple this monologue to an intense observation of their behaviors as they read. Our goal in this part of the interview was to capture participants’ reactions before they could “learn” from the testing situation and from the interviewer asking them questions. This section provided us with a good sense of what participants noticed, where they misinterpreted information, and what they had trouble understanding.
- In the objective question portion of the interview, we asked participants particular questions to gauge what their level of comprehension, their understanding of the relevance of information, how well they connected different pieces of information, and how they used the SBC to make decisions about a health plan. These questions are

designed to assess ease of use as well as whether participants can express more of an understanding of a concept than merely reciting back the words on the page.

Summary of Testing

- 10 one-on-one interviews in Baltimore, MD on August 24-25
- 13 one-on-one interviews in Kansas City, MO on August 25-26
- Interviews consisted of think-aloud on SBC followed by detailed comprehension questions
- Participants saw either Alt 1 or Alt 2 of the comparison document first.
- The initial 3 Baltimore participants saw an original Alt 2 version. All other participants saw a revised Alt 2 version.
- Most participants had average to low health insurance literacy.

Key Demographics

	Baltimore	Kansas City
Language		
English	70%	61%
ESL	30%	39%
Race		
African American	50%	31%
White	40%	69%
Asian	10%	0%
Insurance Status		
Group	60%	46%
Individual	20%	31%

None	20%	23%
Education Level		
Less than HS, HS graduate, or GED	10%	31%
Some college or 2-year program	20%	38%
College graduate	30%	23%
Additional education	40%	8%

Additional Demographics

	Baltimore	Kansas City
Gender		
Male	40%	46%
Female	60%	53%
Marital Status		
Married	20%	38%
Widowed	0%	8%
Divorced	0%	23%
Separated	0%	0%
Never Married	50%	31%
Age		
18-30	40%	31%
31-45	30%	31%

46-60	30%	38%
Household Income		
Less than $35K	10%	31%
$35K-$70K	50%	31%
$70K-$125K	20%	31%
More than $125K	20%	8%

Nelson, Angela

From: Barbra Kingsley <bkingsley@kleimann.com>
Sent: Monday, September 28, 2015 9:25 AM
To: Nelson, Angela; Susan Kleimann
Cc: Kristin Kleimann; Susan Trybula; Cook, Jennifer R.; Mealer, Mary
Subject: Re: Final Report for SBC Testing

Hi!

Congratulations. You all have made some very good and important improvements to the SBC and the Coverage Examples page. Thank you for interpreting our report and applying the findings so well.

The Introductory Page
Wow! This is a great addition and addresses many of the concerns we expressed in the report. You have a clearly stated purpose and you set up the structure of the entire SBC quite nicely. Most consumers should find themselves well-oriented to the entire summary. Placing the alert at the bottom of the page also helps to get the reader into the "meat" of the content more quickly and emphasizes where he/she can get appropriate help. We also liked the use of personal pronouns and active voice to make it easy to read and understand – especially for those of low literacy.

We found the underlined words a bit distracting (but important to do). You might consider placing the explanation that is now at the bottom at the top of the page right before you explain the structure. That way, readers would know why words are underlined from the start, instead of being distracted by them and wondering why they are underlined. You could move only that short explanation and leave the rest of the information at the bottom of the page.

Common Medical Events
The groupings help quite a bit to take away the sense of just one single item after another--e.g. "if you need immediate medical attention," or "If you need help recovering...". The groupings should also help with the misunderstanding around the child dental and eye care. (Quick note: It looks like you have more words capitalized in these listings than in others.)

Coverage Examples
Again, a number of very nice touches, including adding names--although the pictures were a good element. Ideally this page could be tested quickly with numbers inserted and with even your own staff to see if they really get it. That said, it looks like you've done a very interesting combination of the two versions. You provide some detail for the services covered, but it looks like you have blunted the over-interest in the detailed numbers--so you've provided what these participants asked for without distracting them with irrelevant detail. The new format also emphasizes that interaction of deductibles, copays, and coinsurance. We also like the emphasis on “EXAMPLE,” which should help consumers understand that this is for illustrative purposes. It seems to have hit a sweet spot, but again only consumers can tell us for sure.

We hope this feedback is helpful and thank you for allowing us to comments!

Kind regards,
Barbra, Susan, and Kristin

--
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