

Summary of Benefits and Coverage **Instruction Guide for Group Coverage**

Background

Edition Date: January 2021

Applicability: Plans and issuers will be required to use the 2021 edition of the SBC template and associated documents beginning on the first day of the first open enrollment period for any plan years (or, in the individual market, policy years) that begin on or after January 1, 2021, with respect to coverage for plan or policy years beginning on or after that date.

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

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

- Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. The plan or issuer must use 12-point font, and replicate all symbols, formatting, bolding, and shading where applicable. Plans and issuers are encouraged to use the font type Arial Narrow when reproducing the SBC template. Plans and issuers may utilize other font types, such as Arial or Garamond, and modify the margins as necessary to reproduce an SBC provided that it is in a manner that is consistent with the SBC template format and does not exceed 4 double sided pages.
- **Special Rule:** To the extent a plan's terms that are required to be described in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible. Such situations may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement (health FSA) or a health reimbursement arrangement (HRA), or if a plan provides different cost sharing based on participation in a wellness program. Additional examples of flexibility available under this Special Rule include:
 - If the participant is able to select the levels of deductibles, copayments, and coinsurance for a particular benefit package, plans and issuers may combine information for different cost-sharing selections (such as levels of deductibles, copayments, and coinsurance) in one SBC, provided the appearance is understandable. This information can be presented in the form of options, such as deductible options and out-of-pocket

maximum options. In these circumstances, the coverage examples should note the assumptions used in creating them. An example of how to note assumptions used in creating coverage examples is provided in the Departments' sample completed SBC.

- Plans and issuers may combine information for add-ons to major medical coverage that could affect cost sharing (such as a health FSA, HRA, health savings account (HSA), or wellness program) and other information in the SBC, in one SBC if the information is understandable. That is, the effects of such add-ons can be denoted in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. In such circumstances, the coverage examples should note the assumptions used in creating them.
- Terms that are defined in the Uniform Glossary should be underlined in the SBC. Plans and issuers providing an electronic SBC may hyperlink defined terms directly to the Uniform Glossary, ideally directly to the definition in the Uniform Glossary for that term. HHS will maintain a micro-site for the Uniform Glossary at <https://www.healthcare.gov/sbc-glossary/> allowing plans to electronically link defined terms in the SBC directly to the term's definition on the webpage. While providing SBCs with embedded links is not a requirement, the blank template includes embedded hyperlinks. In addition, a list of terms with corresponding anchor links is available on www.cciio.cms.gov. Plans and issuers may also choose to utilize hover text applications in the electronic SBC that allow for a text bubble to appear with the definition when a reader places their cursor over the term.
- Plans and issuers must customize all identifiable company information throughout the document, including websites and telephone numbers.
- Minor adjustments are permitted to row or column size in order to accommodate the plan's information, as long as information is understandable. However, deletion of columns or rows is not permitted unless otherwise noted in these instructions. Additionally, rolling over information from one page to another is permitted.
- The items shown on page 1 must begin on page 1, and the rows of the chart must appear in the same order. However, the chart starting on page 2 may begin on page 2 or in the alternative may be moved to the bottom of page 1 if space allows the first box to appear in its entirety. The rows shown in this chart must appear in the same order. Further, the rows shown on page 2 may extend to page 3 if space requires, and the rows on page 3 may extend to the beginning of page 4 if space requires. The *Excluded Services and Other Covered Services* section must immediately follow the chart that starts on page 2. The *Excluded Services and Other Covered Services* section must be followed by the *Your Rights to Continue Coverage* section, the *Your Grievance and Appeals Rights* section, the *Minimum Essential Coverage/Minimum Value Standard* section, the *Language Access Services* (if applicable), and the *Coverage Examples* section, in that order.
- For all form sections to be filled out by the plan or issuer (particularly in the *Answers* column on page 1, and the *What You Will Pay* and *Limitations, Exceptions, and Other Important Information* columns in the chart that starts on page 2, the plan or issuer should use plain language and present the information in a culturally and linguistically appropriate manner and

utilize terminology understandable by the average individual. For more information, see paragraph (a)(5) of the Departments' regulations.

- The SBC is not permitted to substitute a cross-reference to the Summary Plan Description (SPD) or other documents for any content element of the SBC, except as permitted in the *Limitations, Exceptions, and Other Important Information* column. However, an SBC may include a reference to the SPD in the box at the top of the first page of the SBC. (For example, “Questions: Call 1-800-[insert] or visit us at [www.\[insert\].com](http://www.[insert].com) for more information, including a copy of your plan's summary plan description [or policy documents, if applicable].”) In addition, wherever an SBC provides information that fully satisfies a particular content element of the SBC, it may add to that information a reference to specified pages or sections of the SPD in order to supplement or elaborate on that information.
- Barcodes, control numbers, or other similar language may be added to SBCs by plans or issuers for quality control purposes. Page numbers may be relocated along the bottom of pages to accommodate barcodes, control numbers, or other similar language.
- A plan or issuer may choose to add premium information to the SBC. If the plan or issuer voluntarily adds the premium information, it should be added at the end of the SBC form immediately before the *Your Rights to Continue Coverage* section.
- Plans and issuers with questions about completing the SBC may contact the Department of Health and Human Services at SBC@cms.hhs.gov or the Department of Labor at 866-444-EBSA (3272) or www.askebsa.dol.gov.

Filling out the form

I. GENERAL INFORMATION

Top and Bottom of page 1

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

1. Top Left Header (page 1):

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

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

- Plans and issuers have the option to use their logo instead of typing in the company name if the logo includes the name of the entity sponsoring the plan or issuing the coverage.
- Additional space may be used to add employer/group name if needed.
- The header may roll onto a third line if all required information cannot fit into two lines.
- The plan or issuer must use the commonly known company name.
- Plan names may be generic, such as standard or high option. Additionally, issuer name and plan name are interchangeable in order.

2. Top Right Header (page 1):

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

First line: After *Coverage Period*, the plan or issuer must show the beginning and end dates for the applicable coverage period (such as plan or policy year) in the following format: “MM/DD/YYYY – MM/DD/YYYY”. For example: “Coverage Period: 01/01/2021 - 12/31/2021”.

- 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 01/01/2021”.
- 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, 2021, and a plan year beginning on January 1, 2021 and ending on December 31, 2021: “Coverage Period: 03/15/2021 - 12/31/2021”.

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

Second line:

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

B. Disclaimer (page 1): The disclaimer at the top of page 1 should be replicated exactly, without changes to the font size, graphic, or formatting. The plan or issuer should insert contact information (such as telephone number and/or website) for obtaining more detail or a copy of the complete terms of coverage. Issuers must also include a website where consumers can review and obtain copies of the group certificate of coverage. Finally, the plan or issuer must include a website and telephone number for accessing or requesting copies of the Uniform Glossary. (One or both of the following Internet addresses may be used as a website designated for obtaining the Uniform Glossary: www.dol.gov/ebsa/healthreform or www.cciio.cms.gov, or <https://www.healthcare.gov/sbc-glossary>.)

II. IMPORTANT QUESTIONS/ANSWERS/WHY THIS MATTERS CHART

A. General Instructions for the *Important Questions* chart:

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

1. What is the overall deductible?:

Answers column:

- If there is no overall deductible, answer “\$0”.
- If there is an overall deductible, answer with the dollar amount and, if the deductible is not annual, indicate the period of time that the deductible applies.
- If 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, “\$500 / individual or \$1,000 / family”).

Why This Matters column:

- If there is no overall deductible, show the following language: “See the Common Medical Events chart below for your costs for services this plan covers.”
- If there is an overall deductible, show the following language: “Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.”
- 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.”
- 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.”

2. Are there services covered before you meet your deductible?:

Answers column:

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

Why This Matters column:

- If there are no services covered before the deductible, show the following language: “You will have to meet the deductible before the plan pays for any services.”
- 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 deductible amount. But a copayment or coinsurance may apply.”

- If the plan or coverage is non-grandfathered, insert: “For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <https://www.healthcare.gov/coverage/preventive-care-benefits/>.”

3. Are there other deductibles for specific services?:

Answers column:

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

Why This Matters column:

- If there are no other deductibles, the plan or issuer must show the following language: “You don’t have to meet deductibles for specific services.”
- If there are other deductibles, the plan or issuer must show the following language: “You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.”

4. What is the out-of-pocket limit for this plan?:

Answers column:

- If there are no out-of-pocket limits, answer “Not Applicable.”
- If there is an out-of-pocket limit, respond with a specific dollar amount that applies in each coverage period. For example: “\$5,000”.
- If portraying family coverage, and there is a single out-of-pocket limit for each individual and a separate out-of-pocket limit for the family, show both the individual out-of-pocket limit and the family out-of-pocket limit (for example, “\$1,000 individual / \$3,000 family”).
- If there are separate out-of-pocket limits for in-network providers and out-of-network providers, show both the in-network out-of-pocket limit and the out-of-network out-of-pocket limit. Plans and issuers should use the terminology in the policy or plan document (e.g., in-network, participating, or preferred). For example: “For network providers \$2,500

individual / \$5,000 family; for out-of-network providers \$4,000 individual / \$8,000 family”.

Why This Matters column

- If there is no out-of-pocket limit, the plan or issuer must show the following language: “This plan does not have an out-of-pocket limit on your expenses.”
- 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.”
- 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.”
- 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.”

5. What is not included in the out-of-pocket limit?:

Answers column:

- If there is no out-of-pocket limit, indicate “Not Applicable.”
- 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-billing charges (unless balanced billing is prohibited), and health care this plan doesn’t cover. Depending on the plan, the list could also include: copayments on certain services, out-of-network coinsurance, deductibles, and penalties for failure to obtain preauthorization for services. The plan or issuer must state that these items do not count toward the limit. For example: “Copayments on certain services, premiums, balance-billing charges, and health care this plan doesn’t cover.”

Why This Matters column:

- If there is an out-of-pocket limit, the plan or issuer must show the following language: “Even though you pay these expenses, they don’t count toward the out-of-pocket limit.”
- If there is no out-of-pocket limit, the plan or issuer must show “This plan does not have an out-of-pocket limit on your expenses.”

6. Will you pay less if you use a network provider?:

Answers column:

- If the plan does not use a network, the plan or issuer should answer, “Not Applicable.”
- If the plan or issuer uses a network, the plan or issuer should say “Yes. See [insert direct link or URL address to plan-specific provider directory] or call 1-800-[insert] for a list of network providers.”

Why This Matters column:

- If the plan does not use a network, the following language must be used: “This plan does not use a provider network. You can receive covered services from any provider.”
- If there is a simple in-network/out-of-network coverage arrangement, 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 (balance billing).”
- If the plan uses a tiered network, this language must be used: “You pay the least if you use a provider in [insert tier name]. 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 (balance billing).”
- If the provider uses any form of provider network, 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.”

7. Do you need a referral to see a specialist?:

Answers column:

- If there is a referral required, the plan or issuer should answer, “Yes.”
- If no referral is required, the plan or issuer should answer, “No.”

Why This Matters column:

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

III. COMMON MEDICAL EVENT, SERVICES, WHAT YOU WILL PAY, AND LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION

A. General Instructions:

1. Location of Chart:

This chart should begin on page 2 (or at the bottom of page 1, if space allows) and the rows shown on pages 2 and 3 must appear in the same order. However, the rows shown on page 2 may extend to page 3 if space requires, and the rows shown on page 3 may extend to the beginning of page 4 if space requires. The heading of the chart must appear on the top of all pages used.

If a deductible applies, plans and issuers must include the disclaimer, as shown in the template, with language “All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.” at the top of the Common *Medical Event* chart.

2. *What You Will Pay* columns:

- Plans and issuers may vary the number of columns depending upon the type of coverage and the number of preferred provider networks. Most plans or issuers that use a network should use two columns, although some plans or issuers with more than one level of in-network provider may use three columns. Non-networked plans may use one column.
- The columns are intended to reflect the consumer costs after the deductible has been satisfied.
- Plans and issuers should denote in these columns exceptions, such as when a specific service is subject to a separate deductible or is covered at no cost.
- Plans and issuers should insert the terminology used in the policy or plan document to title the columns. For example, the columns may be called “Network Provider” and “Out-of-Network Provider”, or “Preferred Provider” and “Non-Preferred Provider” based on the terms used in the policy. The sub-headings should be deleted for non-networked plans with only one column.
- The columns should appear from left to right, from most generous cost sharing to least generous cost sharing. For example, if a 3-column format is used, the columns might be labeled (from left to right) “Network Preferred Provider”, “Network Provider”, and then “Out-of-Network Provider”.
- For HMOs providing no out-of-network benefits, the plan or issuer should insert “Not covered” in all applicable boxes under the far-right sub-heading under the *Your Cost* column (which, for coverage providing out-of-network benefits, would usually be out-of-network provider or non-preferred provider column).
- Plans and issuers must complete the responses under these sub-headings based on how the plan or issuer covers the specific services listed in the chart after the deductible has been satisfied. Fill in the *What You Will Pay* column(s) with the coinsurance percentage, the copayment amount, “No charge” if the employee pays nothing, or “Not covered” if the service is not covered by the plan. When referring to coinsurance, include a percentage valuation. For example: “20% coinsurance”. When referring to copayments, include a per occurrence cost. For example: “\$20/visit” or “\$15/prescription”.
- If the plan has a deductible and the deductible does not apply to a particular benefit, the plan or issuer should insert “Deductible does not apply”.
- Refer to the specific additional instructions below for details on completing the *What You Will Pay* columns in the chart for the following common medical events:

- If you visit a health care provider’s office or clinic;
- If you need drugs to treat your illness or condition; and
- If you need mental health, behavioral health, or substance abuse services.

3. *Limitations, Exceptions, & Other Important Information* column:

a. Core limitations, exceptions, and other important information

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

- When a service category or a substantial portion of a service category is excluded from coverage (i.e., column should indicate “brand name drugs excluded” in health benefit plans that only cover generic drugs);
- When cost sharing for covered in-network services does not count toward the out-of-pocket limit;
- Limits on the number of visits or on specific dollar amounts payable under the health benefit plan; and
- When prior authorization is required for services.

b. Special Rule for 3.a. Core limitations, exceptions, and other important information

Plans and issuers must accurately describe as many core limitations and exceptions specified in 3.a. as reasonably possible, in a manner that is consistent with the instructions and template format. To the extent that the inclusion of all such limitations and exceptions would make compliance with the four double-sided page limit not reasonably possible, for each set of limitations or exceptions that cannot be fully described, the plan or issuer should cross reference the pages or identify the sections where the limitations and exceptions are described in the applicable document that fully describes the limitations and exceptions, such as the relevant pages of the summary plan description or policy document, in order to limit the length of the SBC to four double-sided pages.

For example, if a plan would have to show “Speech-generating devices are limited to \$1,250/calendar year, no coverage for other communications equipment, devices, or aids” and inclusion of this information would cause the SBC to exceed the four double-sided page limit, in the “*Limitations, Exceptions, and Other Important Information*” column plans and issuers should include “*See section X.” At the bottom of each applicable page, the plan should include the following language “*For more information about limitations and exceptions, see plan or policy document at [www.insert.com].”

c. Other significant limitations, exceptions, and other important information

Significance of other limitations, exceptions, and other 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 consumers, 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*”.

- Information provided should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows: “XX visit limit”, “No coverage for XXX”, “\$XX/visit limit”, and/or “\$XX annual max”.
- If the plan or issuer requires the participant or beneficiary to pay 100% of a service in-network, then that should be considered an “excluded service” and should appear in the *Services Your Plan Generally Does Not Cover* box following the chart. For example, coverage that excludes services in-network such as habilitation services, prescription drugs, or mental health services, must show these exclusions in the *Services Your Plan Generally Does Not Cover* box.
- If the health benefit plan has a preauthorization requirement that includes a penalty when a participant or beneficiary fails to obtain preauthorization, 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.
- If there are no items that meet the significance threshold described above, then the plan or issuer should show “None” 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.
- Refer to the specific instructions below for details on completing the *Limitations, Exceptions, and Other Important Information* column.

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

1. If you visit a health care provider’s office or clinic:

- The plan or issuer should always include, in a separate paragraph at the end of the *Limitations, Exceptions, & 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 plan or issuer does not combine the services (the rows) for the Common Medical Event into one box, this statement should always appear in line with “Preventive care/screening/immunization”.
- If space allows (i.e., the four double sided page limit would not be exceeded), plans and issuers may include information on additional types of practitioners, such as a nurse practitioners or physician assistants.

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

- Under the *Common Medical Events* column, provide a direct link or URL address to the

formulary drug list where the participant or beneficiary can find more information about prescription drug coverage for this plan. If there is no website, provide a contact phone number where the participant or beneficiary can receive more information about prescription drug coverage for this plan.

- Under the *Services You May Need* column, the plan or issuer should list and complete the categories of prescription drug coverage under the plan (for example, the issuer might fill out 4 rows with the terms, “Generic drugs”, “Preferred brand drugs”, “Non-preferred brand drugs”, and “Specialty drugs”). Plans and issuers may describe tiered formularies using the terminology used by the plan. However, to the extent that a plan is using plan terminology to describe its tiered formulary, the plan or issuer should also include the corresponding terms (such as generic, preferred, non-preferred, or specialty) used in the SBC to describe formularies in parentheses, as applicable. For example, in the “Services You May Need” column, a plan or issuer might add “Tier 1” next to “(Generic drugs)”, if Tier 1 is the term used to label generic drugs in the plan or policy’s formulary.
- Under the *What You Will Pay* column, plans and issuers should include the cost sharing for both retail and mail order, as applicable.

3. If you have outpatient surgery:

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

4. If you have a hospital stay:

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

5. If you need mental health, behavioral health, or substance abuse services:

- If the cost sharing differs for inpatient or outpatient services for mental health, behavioral health, or substance abuse services show the cost sharing for each. For example, a plan or issuer might show that the cost sharing for mental health, behavioral health, or substance abuse outpatient services as “\$35 copay/office visit and 20% coinsurance for other

outpatient services”.

6. If you are pregnant:

- If applicable, plans and issuers should include an explanation in the *Limitations and Exceptions* column that describes that the cost-sharing amounts listed may not apply to some services. The plan or issuer should determine which, if any, of the following sentences to include:
 - “Cost sharing does not apply 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 (i.e., ultrasound).”

7. If you need help recovering or have other special health needs:

- If applicable, exclusions and limitations for physical Therapy, Occupational Therapy and Speech Therapy services must be listed in the *Limitations, Exceptions, & Other Important Information* column for the Rehabilitation services and Habilitation services rows.
- If there is a quantitative limit (for example, number of days, hours, or visits covered) applicable to that service, those limits must be specified.

IV. DISCLOSURES

The *Excluded Services and Other Covered Services*, *Your Rights to Continue Coverage*, *Your Grievance and Appeals Rights*, *Minimum Essential Coverage/Minimum Value Standard*, *Language Access* (if applicable), and *Coverage Examples* sections must always appear in the order shown. The *Excluded Services and Other Covered Benefits* must always follow immediately after the chart that starts on page 2.

A. Excluded Services and Other Covered Services:

- Each plan or issuer must place all services listed below in either the *Services Your Plan Generally Does Not Cover* box or the *Other Covered Services* box according to the plan provisions. The required list of services includes:
 - Acupuncture
 - Bariatric surgery
 - Chiropractic care
 - Cosmetic surgery
 - Dental care (Adult)
 - Hearing aids
 - Infertility treatment
 - Long-term care
 - Non-emergency care when traveling outside the U.S.
 - Private-duty nursing
 - Routine eye care (Adult)
 - Routine foot care
 - Weight loss programs

- The plan or issuer may not add any other benefits to the *Other Covered Services* box other than the ones listed above. However, other benefits must be added to the *Services Your Plan Generally Does Not Cover Box* if the plan or issuer requires the participant or beneficiary to pay 100 percent of the service in-network. For example, coverage that excludes services in-network, such as habilitation services, prescription drugs, or mental health services, must show these exclusions in the *Services Your Plan Generally Does Not Cover* box.
- List placement must be in alphabetical order for each box. The lists must use bullets next to each item.
- While not required, the plan or issuer may choose to indicate whether abortion services are covered. If a plan or issuer voluntarily chooses to include information regarding coverage of abortion services, plans or issuers that cover excepted and non-excepted abortion services should list “Abortion” in the *Other Covered Services* box. Plans or issuers that exclude all abortions should list “Abortion” in the excluded services box. Plans or issuers 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 another plan or policy document that more fully describes the exceptions.
- 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](#).”
- For those services shown in the *Other Covered Services* box, plans and issuers must describe any limitations that may apply. For example, the following statement might be shown in the *Other Covered Services* box, as follows: “Acupuncture if it is prescribed by a physician for rehabilitation purposes.”
- For example, if a plan or issuer excludes all of the services on the list above except Chiropractic services, and also showed exclusion of Habilitation Services on page 2, the *Other Covered Services* box would show “Chiropractic Care” and the *Services Your Plan Generally Does Not Cover* box would show “Acupuncture, Bariatric Surgery, Cosmetic surgery, Dental care (Adult), Habilitation Services, Hearing Aids, Infertility treatment, Long-term care, Non-emergency care when traveling outside the U.S., Private-duty nursing, Routine eye care (Adult), Routine foot care, Weight loss programs”.

B. Your Rights to Continue Coverage:

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

- For group health coverage subject to ERISA, [insert contact information for the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or

www.dol.gov/ebsa/healthreform].

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

C. Your Grievance and Appeals Rights:

This section must appear as shown on the template. Contact information should be inserted as follows (more than one of these instructions may be applicable):

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

D. Minimum Essential Coverage/Minimum Value Standard:

The following questions and statements must appear, immediately following, *Your Grievance and Appeals Rights* and the plan or issuer must provide the appropriate answer:

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? [Yes/No/Not Applicable]

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

The concept of minimum value is not relevant with respect to individual market coverage and

issuers of individual market coverage should answer “Not Applicable.”

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

- In order to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules in the claims and appeals regulations under PHS Act section 2719. Plans and issuers can find written translations of the SBC template and uniform glossary in non-English languages at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html>.
- **FOR QUALIFIED HEALTH PLANS:** For an SBC prepared for a qualified health plan (QHP) offered through a SHOP Marketplace, the issuer must include an addendum with 15 language taglines as required by 45 C.F.R. §§ 155.205(c)(2)(iii) and 156.250. If any additional taglines are required under PHS Act 2719 they must also be included in this addendum. For example, if Navajo meets the requirements under PHS Act action 2719 but is not included in the 15 language tag line requirement under 45 C.F.R. § 155.205(c)(2)(iii), a plan or the issuer must include the Navajo tag line in addition to the 15 required language tag lines in the addendum. The addendum, which must only include tagline information required by language access standards for critical documents, will not count towards the page limit.

V. COVERAGE EXAMPLES

- The U.S. Department of Health and Human Services (HHS) will provide all plans and issuers with standardized data to be inserted in the *Total Example Cost* section for the coverage examples. This information is reflected in the 2021 edition of the SBC template.
 - HHS will also provide underlying detail that will allow plans and issuers to calculate *In this example [Patient] would pay* amounts, including: Date of Service, medical coding information, Provider Type, Category, descriptive Notes identifying the specific service provided, and Allowed Amounts.
 - All plans and issuers will be allowed continued use of the Coverage Examples Calculator. For the calculator, instructions, and logic, see <https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/index.html#Summary%20of%20Benefits%20and%20Coverage%20and%20Uniform%20Glossary>
- Plans and issuers should specify cost-sharing category for each line of the template to accurately reflect the plan. For example, a plan that applies a copayment to a specialist visit must replace “[cost sharing]” with “copayment”, i.e. “Specialist copayment”.
- Each plan or issuer must calculate cost sharing, using the detailed data provided by HHS, and populate the *Patient pays* fields. Dollar values are generally to be rounded off to the nearest hundred dollars (for sample care costs that are equal to or greater than \$100) or to

the nearest ten dollars (for sample care costs that are less than \$100), in order to reinforce to consumers that numbers in the examples are estimates and do not reflect their actual medical costs. For example, if the coinsurance amount is estimated at \$57, the issuer would list “\$60” in the appropriate *In this example, [Patient] would pay* section of the Coverage Examples.

- If applying the rounding rules causes the deductible amount displayed to exceed the actual overall deductible (for self-only coverage), then the deductible amount must be capped and shown as the amount of the actual deductible. For example, if the overall deductible is \$1,750 and will be satisfied, then the plan or issuer must show “\$1,750” and not “\$1,800”.
- If applying the rounding rules causes the cost-sharing amount displayed to exceed the actual out-of-pocket limit (for self-only coverage), then the cost-sharing amount must be capped and the amount of the actual out-of-pocket limit must be used. For example, if the out-of-pocket limit is \$5,000 but applying the rounding rules makes the sum of the deductible, copayment and coinsurance equal to \$5,100, the plan or issuer must use the out-of-pocket limit of “\$5,000” and not “\$5,100”. This amount (the \$5,000 out-of-pocket limit) must then be added to the monetary amount in the exclusions and limits to determine the total *Patient pays* amount.
- Services on the template provided by HHS are listed individually for classification and pricing purposes to facilitate the population of the appropriate *In this example, [Patient] would pay* section. HHS specifies the Category used to roll up detail costs into the *Total Example Cost* category section. Some plans may classify that service under another category and should reflect that difference accordingly. The plan or issuer should apply their cost sharing and benefit features for each plan in order to complete the *In this example [Patient] would pay* section, but must leave the *Total Example Cost* section as is. Examples of categories that might differ between the *In this example, [Patient] would pay* and *Total Example Cost* sections could include, but are not limited to:
 - Payment of services based on the location where they are provided (inpatient, outpatient, office, etc.)
 - Payment of items as prescription drugs vs. medical equipment
- Each plan or issuer must calculate and populate the *In this example [Patient] would pay* total and sub-totals based upon the cost sharing and benefit features of the plan for which the document is being created. For plans and issuers that combine information for different coverage tiers in one SBC, the coverage examples should be completed using the cost sharing (for example, deductible, and out-of-pocket limits) for the self-only coverage tier (also sometimes referred to as the individual coverage tier). In addition, the coverage examples should note this assumption. These calculations should be made using the order in which the services were provided (Date of Service).
 - **Deductible** – includes everything the participant or beneficiary pays up to the deductible amount. Any copayments that accumulate toward the deductible are

accounted for in this cost-sharing category, rather than under copayments.

- **Copayment** – those copayments that don't apply to the deductible.
- **Coinsurance** – anything the participant or beneficiary pays above the deductible that's not a copayment or non-covered service. This should be the same figure as the Total less the Deductible, Copayments and Limits or exclusions.
- **Limits or exclusions** – anything the participant or beneficiary pays for non-covered services or services that exceed plan limits.
- If the plan has a wellness program that varies the deductibles, copayments, coinsurance, or coverage for any of the services listed in a treatment scenario, the plan or issuer must complete the calculations for that treatment scenario assuming that the patient is NOT participating in the wellness program. Additionally, if applicable, the plan or issuer must include a box below the coverage examples with the following language (and appropriate contact information): “Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].”
- If the plan has deductibles for specific services included in the coverage example, that cause the deductible amount in the *In this example [Patient] would pay* deductible section to exceed the overall deductible amount listed, add a * next to the deductible in the *In this example [Patient] would pay* table. Additionally, plans must include a box below the coverage examples with the following language: “This plan has other deductibles for specific services included in this coverage example. See “Are there other deductibles for specific services?” row above.”
- If all of the costs associated with the Coverage Examples are excluded under the plan, then the phrase “(This condition is not covered, so patient pays 100 percent)” is added after the *In this example, [Patient] would pay* amount. Otherwise no narrative should appear after the *In this example [Patient] would pay* amount.

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