

Understanding the Summary of Benefits and Coverage (SBC)

Fast Facts for Assisters

This Fact Sheet Provides Guidance to Help Assisters:^{i,ii}

- Interpret the Summary of Benefits & Coverage (SBC) for health plans
- Assist consumers with using the SBC to compare health plan benefits

Summary of Benefits & Coverage: Overview

To help consumers compare the different features of health benefits and coverage, the Affordable Care Act generally requires all group health plans and health insurance companies to provide individuals a “summary of benefits and coverage” that “accurately describes the benefits and coverage under the plan.”

The SBC is a snapshot of a health plan’s costs, benefits, covered health care services, and other features that are important to consumers. SBCs also explain health plans’ unique features like cost sharing rules and include significant limits and exceptions to coverage in easy-to-understand terms. Along with the SBC, group health plans and health insurance companies must also provide a Uniform Glossary to explain common medical and insurance-related terms. **This fact sheet focuses on the SBC provided by health insurance companies that offer coverage through the Marketplaces. The sample SBC used below is for illustrative purposes only and is not intended to reflect any Marketplace plan option.** As consumers compare qualified health plans (QHPs) offered through the Marketplaces, you can help them figure out some of the benefits offered in each plan by walking them through the SBC.

What Assisters Need to Know About Locating the SBC

Consumers may access the SBC within each health plan’s detailed view at HealthCare.gov. Refer to Exhibit 1 for an example of a health plan’s detailed view, which allows consumers to learn more about health plan options before they select one and enroll.


Exhibit 1: Health Plan Details with SBC

CareSource · CareSource Silver

Silver | HMO | Plan ID: 54192IN0010014

Monthly premium	Deductible
\$388.55	\$3,900 Individual total

Documents

-  [Summary of Benefits](#)
- [Plan brochure](#)
- [Provider directory](#)

Dental

- ✓ Child dental benefit included
- ✗ Adult Dental benefit not included

What Assisters Need to Know When Reviewing the SBC with Consumers

Assisters should help consumers understand that all SBCs consist of the following basic parts:

- **Important Questions:** Consumers can use this section to understand some of the health plan's costs, including deductible amounts and out-of-pocket limits. This section also contains information on coverage for in-network and out-of-network providers.
- **Common Medical Events:** This section provides cost sharing information for certain common medical events (such as copayments and coinsurance amounts) and significant limitations or exclusions. Services described include a visit to a provider's office, having an MRI or CAT scan, having a hospital stay, and prescription drug information.
- **Excluded Services and Other Covered Services:** Consumers can refer to this section to learn about certain services that are not covered by their health plan, as well as some additional services the plan does cover.

- **Coverage Examples:** All SBCs include examples of how a plan might cover a hypothetical consumer’s health care costs for sample health conditions, such as pregnancy or type 2 diabetes. Consumers should not use these coverage examples to estimate their actual costs under a plan because actual services and costs depend on consumers’ individual medical needs when they consult with a provider. Instead, consumers should use the examples to get an idea of how much financial protection the plan is generally expected to provide for common health conditions. These standardized, hypothetical coverage examples can help consumers facilitate apples-to-apples comparisons between plans.
- **Uniform Glossary:** Each SBC contains a link to a glossary with consumer-friendly explanations of common medical and insurance terms, such as “deductibles” and “premiums.” All health insurance issuers use the same glossary. You can find the Uniform Glossary online, here: <https://www.healthcare.gov/sbc-glossary/>.

You should remind consumers that they can use the SBC to answer their general questions about a health plan before selecting a plan for enrollment. Consumers can contact the insurance company offering a plan for information about how it can help them pay for specific health services, and they should review the insurance policy closely. You should also remind consumers that their benefits and coverage under a health plan may change during the benefit year, although this is not common, or when a new benefit year begins, which is very common. If information on a plan’s SBC changes in the middle of a benefit year, the health insurance company offering that plan must notify consumers of any changes at least 60 days before they go into effect. Before a new benefit year begins, consumers should expect a new SBC from their health insurance company that reflects any changes to their plan that will be in effect during the new benefit year.

Scenario: Using the Summary of Benefits to Help a Consumer Choose a Health Plan

Ella, a 28-year-old consumer, wants to enroll in a health plan for herself and her husband for the first time. You help Ella submit a Marketplace application and she is determined eligible to purchase a QHP through the Marketplace. Ella has chronic back pain and her husband suffers from asthma, so she’s identified a QHP that she believes will provide good coverage for her and her husband’s conditions. However, Ella might need back surgery this year so she is concerned about the plan’s prescription drug costs and any costs she may be responsible for if she visits a specialist outside the plan’s network. You help Ella review the SBC to learn more about this plan and she asks you following questions:




1. My last doctor said I might need to have in-patient back surgery in the next year. Do I need to get a referral to see a back specialist?

First, direct Ella to the Important Questions chart of the SBC. One important question and answer on this chart shows whether Ella would need a referral before she sees a specialist. A sample Important Questions chart is displayed below in Exhibit 2.

Exhibit 2: Sample Important Questions Chart

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2018 – 12/31/2018
Coverage for: Family | Plan Type: PPO

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at [www.\[insert\].com](#) or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500/Individual or \$1,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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 .
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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/ .
Are there other deductibles for specific services?	Yes. \$300 for prescription drug coverage and \$300 for occupational therapy services.	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.
What is the out-of-pocket limit for this plan ?	For network providers \$2,500 individual / \$5,000 family; for out-of-network providers \$4,000 individual / \$8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. 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.
What is not included in the out-of-pocket limit ?	Copayments for certain services, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers .	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). 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.
Do you need a referral to see a specialist ?	Yes.	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 .

2. If I do need surgery, how much will it cost me to have a surgery on this plan?

You should inform Ella that the SBC cannot tell her the exact costs she will pay for a complicated episode of care like back surgery. Her actual services and costs would depend on her particular medical needs, as determined in consultation with her provider. However, you can show Ella two sections of the SBC that will help her understand potential cost-sharing amounts for services she will receive if she gets back surgery.


First, direct Ella to the Important Questions chart of the SBC. Explain that Ella must meet the deductible amount in the first row before the insurance company would begin to pay for covered services. In this example, the plan has a \$500 per person overall deductible and a \$300 specific deductible for prescription drug coverage.

Next, direct Ella to the Common Medical Events chart shown in Exhibit 3 below. This chart starts on the next page of the SBC and shows the potential cost-sharing amounts Ella might be responsible for if she received various health care services after meeting the plan's deductible(s). For example, an office visit with a specialist in the plan's network has a \$50 copayment per visit for a participating provider, which means Ella would need to pay \$50 each time she visits an in-network (participating) specialist. If Ella went to a nonparticipating provider outside this plan's network, she would have to pay 40 percent coinsurance, or 40 percent of the allowed amount for the visit. For example, if the plan's allowed amount for an out-of-network (nonparticipating) specialist visit is \$200, her coinsurance payment of 40 percent would be \$80. This amount assumes that she has met her deductible. Also, if the out-of-network specialist's charge is more than the plan's allowed amount, the provider may charge her for the difference between the provider's charge and the plan's allowed amount (sometimes called "balance billing"). For example, if the specialist's charge was \$250 in the example above, Ella could have to pay \$50 (\$250 specialist charge minus \$200 plan allowed amount), plus the \$80 coinsurance, for a total cost of \$130. This is why it is often beneficial for enrollees to look for in-network providers, where out-of-pocket costs are typically lower.

Ella should also pay attention to the "If you have a test" row of the Common Medical Event chart to determine the potential cost sharing for having an imaging test performed, like an MRI or CT/PET scan. Ella can find other services she may need, in the Common Medical Event chart as well, including "If you have outpatient surgery" and "If you have a hospital stay." Either of these rows may apply, depending on whether her surgery would be performed in an outpatient or inpatient setting.



Exhibit 3: Sample Page from Common Medical Events Chart

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.				
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & 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	\$35 copay /office visit and 20% coinsurance for other outpatient services; deductible does not apply	40% coinsurance	None
	Specialist visit	\$50 copay /visit	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	Preventive care/screening/immunization	No charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	\$10 copay /test	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$50 copay /test	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs (Tier 1)	\$10 copay /prescription (retail & mail order)	40% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	\$30 copay /prescription (retail & mail order)	40% coinsurance	
	Non-preferred brand drugs (Tier 3)	40% coinsurance	60% coinsurance	
	Specialty drugs (Tier 4)	50% coinsurance	70% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100/day copay	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service. 50% coinsurance for anesthesia.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	\$30 copay /visit	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by

For the most accurate information about specific services Ella is interested in, she can use the contact information at the top of the first page of the SBC to contact the plan's issuer and request a copy of the actual plan or policy document. This document provides detailed information about specific benefits covered under a plan. Refer to Exhibit 4.

Exhibit 4: Sample Contact Information for More Details about Coverage

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2018 – 12/31/2018
Coverage for: | Plan Type: PPO



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3. *All these services and costs seem to be adding up quickly! Does this plan offer any protection for me if I have to pay a lot out-of-pocket in one coverage year?*

To answer this question, return to page 1, shown in Exhibit 2, and find the row for “What is the out-of-pocket limit for this plan?” The out-of-pocket limit, as explained in the Uniform Glossary, is the most Ella could pay during a policy period (usually a year) before her health insurance company begins to pay 100 percent of the allowed amount. In this example, if Ella spends over \$2,500 for services from in-network (or participating) providers, the health insurance company will begin to pay 100 percent of the allowed amount. As this plan’s SBC shows, the out-of-pocket limit never includes premiums, balance-billed charges¹, or health care the health insurance company doesn’t cover. Additionally, some health insurance companies don’t count all copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

4. *Thanks! Now that I know how to interpret the cost sharing features of a plan using the SBC, maybe I should look at another SBC to see how this plan matches up to another plan I was considering earlier.*

Tell Ella that using the SBC to make apples-to-apples comparisons easier is exactly one of the main purposes of the SBC. If she doesn’t have ready access to the other SBC, she can always request it from the insurance company, which must send it within seven business days.

Additional Resources

For more information visit:

- **CMS:** Summary of Benefits and Coverage
Available at: <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html>

¹ For a definition of balance billing, go to: <https://www.healthcare.gov/sbc-glossary/#balance-billing>.

- **HealthCare.gov:** Overview of Summary of Benefits and Coverage
Available at: <https://www.healthcare.gov/how-does-the-health-care-law-protect-me/summary-of-benefits-and-coverage/>
- **Marketplace.cms.gov:** A presentation on the Summary of Benefits and Coverage
Available at: <https://marketplace.cms.gov/technical-assistance-resources/summary-of-benefits-and-coverage-overview.pdf>.

ⁱ The information provided in this document is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. Links to certain source documents have been provided for your reference. We encourage all assisters to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

ⁱⁱ This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

