CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Summary of Benefits and Coverage

April 2024

The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance that it is based upon. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information. This communication was produced and disseminated at U.S. tax filer expense.

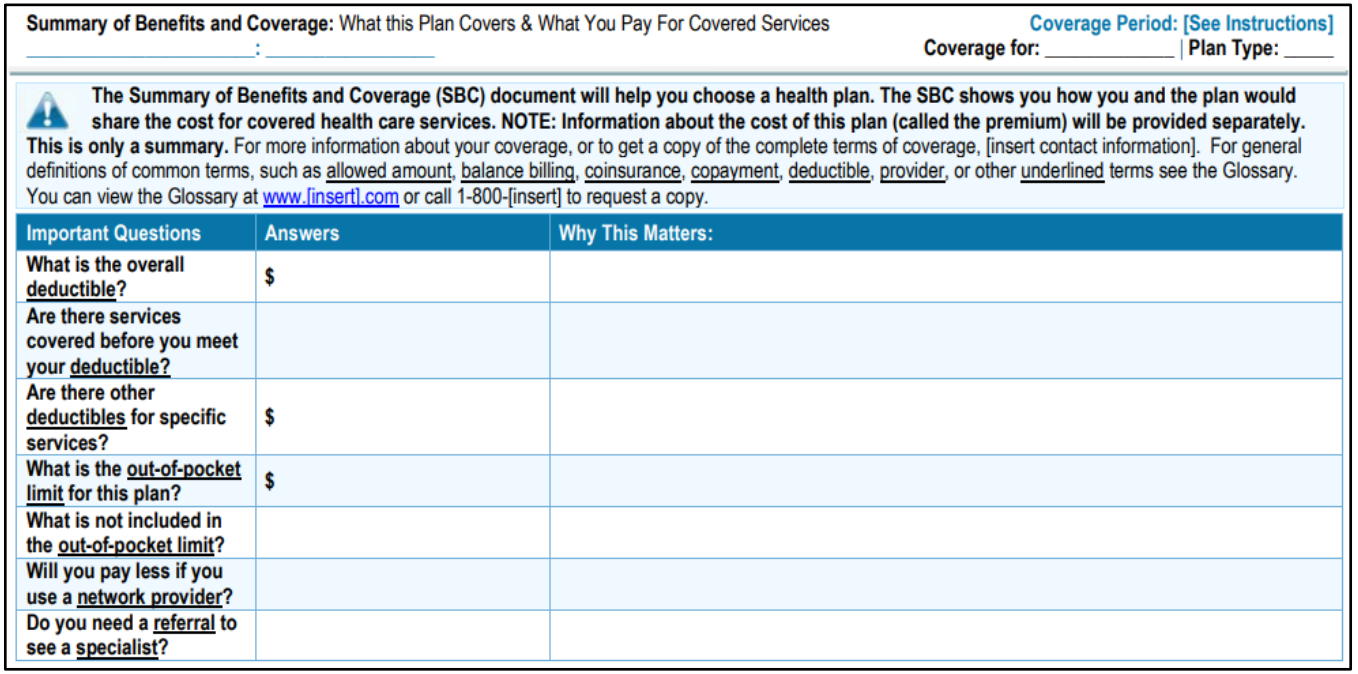
CSG-202404

Agenda

- What is the Summary of Benefits and Coverage (SBC)?
- The “who, when, how”:
  - Who gets an SBC?
  - When do they get an SBC?
  - How do they get an SBC?
- The six parts of the SBC

What is the Summary of Benefits and Coverage (SBC)?

- Required under section 2715 of the Public Health Service Act, which was added by the Affordable Care Act (ACA)
- A consumer shopping tool that provides a snapshot of a plan's benefits, coverage, and limitations and exceptions
- Presents information on a plan's benefits in a uniform format for easy comparison



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

_____: _____

Coverage Period: [See Instructions]

Coverage for: _____ | **Plan Type:** _____

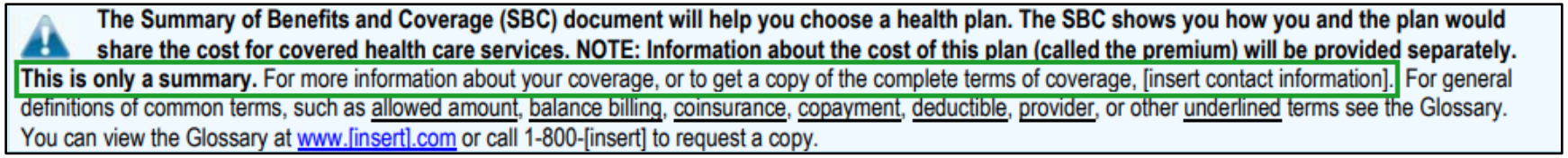
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

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?	$	
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?		

Limits of the SBC

- Only provides a summary
- Benefits and coverage may change during the benefit year or at the start of a new benefit year



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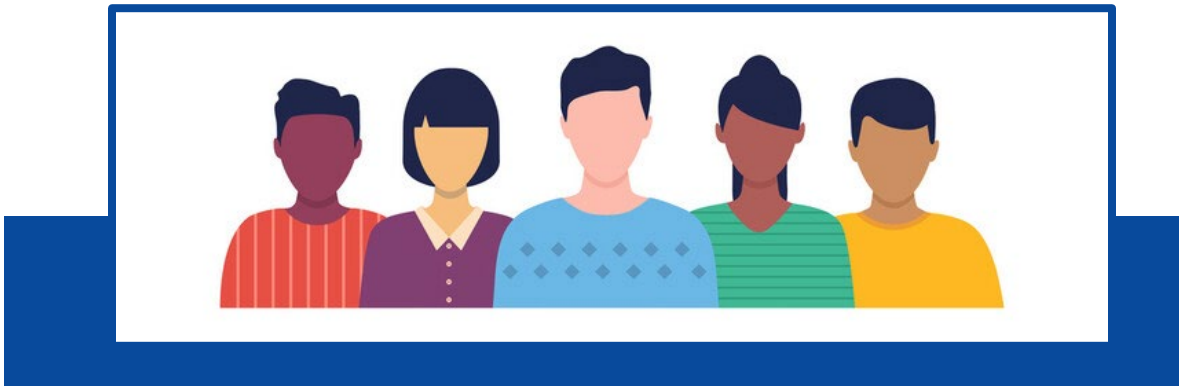
Who Came Up With the SBC?

- Department of Health and Human Services (HHS), Department of Labor (DOL), and Department of the Treasury (the Treasury)
- Stakeholders:
  - Consumer groups
  - Health plan trade associations
  - Provider trade associations
  - State insurance commissioners

Knowledge Check #1

The benefits and cost-sharing features identified in a plan's SBC will always remain the same for the entire coverage year.

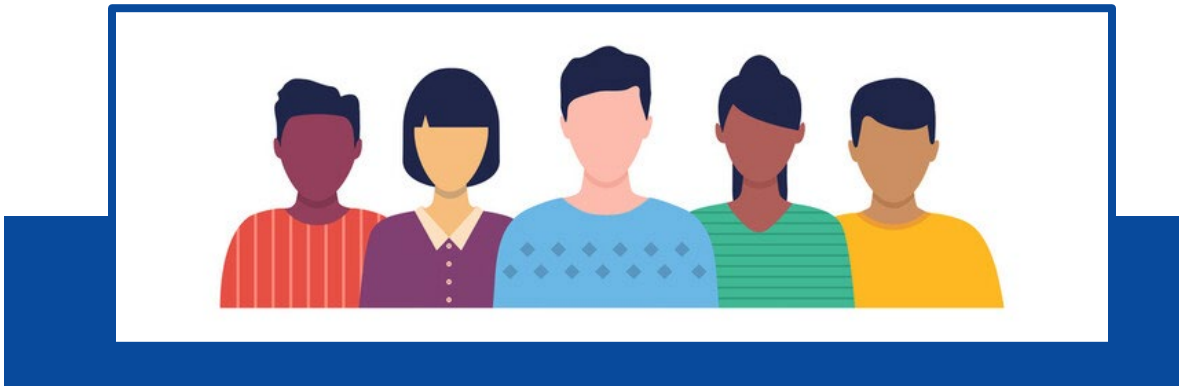
True or False?



Knowledge Check #1 Answer

The benefits and cost-sharing features identified in a plan's SBC will always remain the same for the entire coverage year.

False



When Did Plans and Issuers Start Providing SBCs?

- Original SBC template was implemented in September 2012 and was modified April 2016 and February 2020.
- Plans and issuers are required to use the 2023 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, 2023, with respect to coverage for plan or policy years beginning on or after that date.

Who Needs to Provide an SBC?

- Group health plans and issuers offering group or individual health insurance coverage
- Issuers must provide an SBC to applicants, enrollees, and policyholders or certificate holders

When Must an SBC be Provided?

- **When an application is received:** As soon as practicable, but no later than seven business days following an application being received for individual or group health insurance coverage.
- **By the first day of coverage:** If there are any changes to the content of the SBC, then the new SBC must be provided no later than the first day of coverage.

When Must an SBC be Provided? (Cont.)

- **Upon renewal, reissuance, or re-enrollment:**
  - If a written application is required for renewal, an SBC must be provided no later than the date application materials are distributed.
  - If renewal is automatic, a new SBC generally must be provided at least 30 days before the beginning of the new plan or policy year.
  - If the policy, certificate, or contract of insurance has not been issued or renewed 30 days before the beginning of the new plan year, an SBC must be provided as soon as practicable, and **no later than seven business days** after issuance of the new policy, certificate, or contract of insurance.

When Must an SBC be Provided? (Cont.)

- **Upon request:** As soon as is practicable, but no later than seven business days following the request for an SBC or summary information about the health coverage.
- **For consumers who enroll during a Special Enrollment Period (SEP):** Required to be provided no later than 90 days from enrollment. However, a consumer who is eligible for an SEP (but not yet enrolled) may request an SBC for the benefit packages for which they are eligible.

Material Modifications

If a plan or issuer makes a "material modification" to any of the terms of the plan or coverage that would affect the content of the SBC, other than in connection with renewal or reissuance of coverage, the plan must notify enrollees of this change.

- Not necessary to supply a new SBC
- Notification generally must be provided to affected enrollees no later than 60 days prior to the modification becoming effective

Knowledge Check #2

At which of these times must consumers be provided an SBC?

A. When they enroll in a new plan

B. Whenever they request one

C. Every other month they are enrolled in the plan

D. At the time of renewal or re-enrollment in their plan

E. A, B, and D

Knowledge Check #2 Answer

At which of these times must consumers be provided an SBC?

A. When they enroll in a new plan

B. Whenever they request one

C. Every other month they are enrolled in the plan

D. At the time of renewal or re-enrollment in their plan

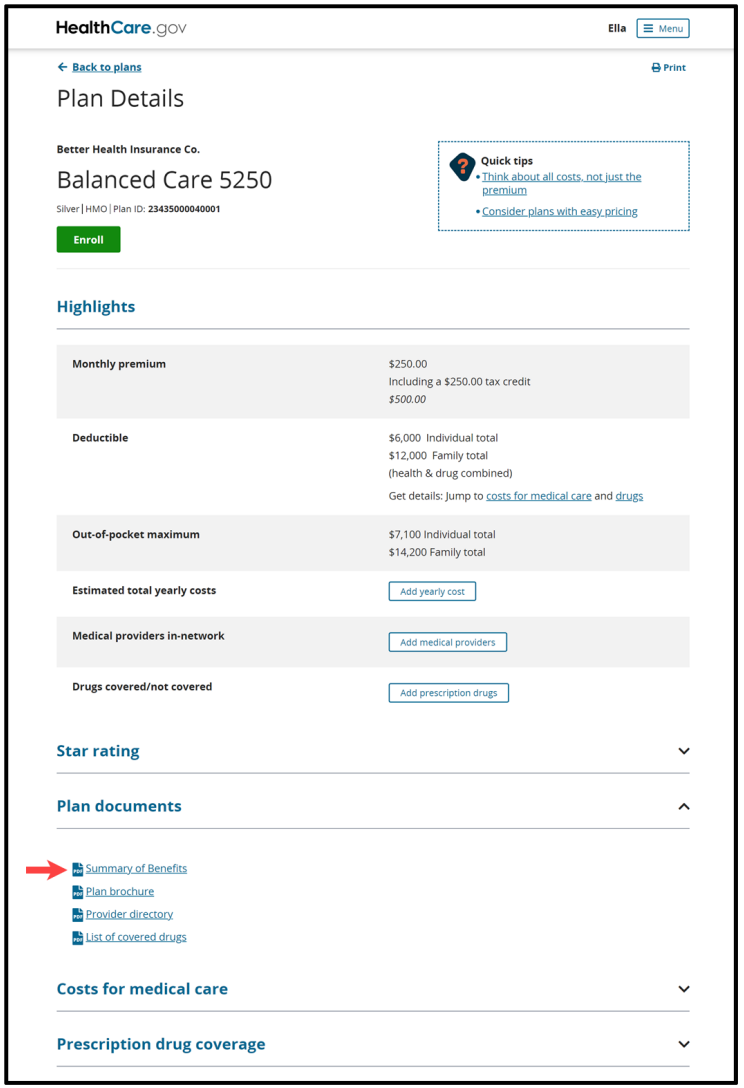
E. A, B, and D

How Must an SBC be Provided?

- An SBC can be made available in either paper or electronic format (either online or via email).
- If posted online, it must be in a manner that is:
  - Prominent
  - Readily accessible
- Notification must be given that a free paper copy of the SBC is available upon request.

Where Can a Consumer Access the SBC When Shopping for Marketplace Coverage?

In the “Plan Details” section of HealthCare.gov:



What's Required to be in the SBC?

- Information about the uniform glossary of insurance and medical terms
- A contact phone number to obtain a paper copy

- A description of the coverage for each category of benefits
- Information about limitations, exceptions and excluded services

- The cost sharing under the plan or policy, including deductible, coinsurance, and copayment amounts

What's Required to be in the SBC? (Cont.)

- The renewability and continuation of coverage provisions
- Coverage examples

- An internet address for obtaining a copy of the individual coverage policy or group certificate of coverage
- An internet address for obtaining a list of network providers (direct link)

- An internet address for obtaining information on prescription drug coverage (direct link)

What's Required to be in the SBC? (Cont.)

- For qualified health plans (QHPs), certain information about abortion coverage
- Minimum essential coverage and minimum value disclosures
- Information about consumers' rights regarding language access services, continuing coverage, and grievance and appeals
- A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance ultimately controls coverage
- Contact information for questions

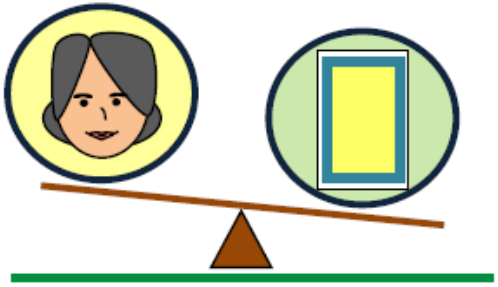
The Main Parts of the SBC

- Uniform Glossary
- Important Questions
- Common Medical Events
- Excluded Services and Other Covered Services
- Coverage Examples
- Disclosures

The Uniform Glossary

- Provides consumer-friendly definitions for common health coverage and medical terms
- Uniform across all plans and issuers
- Available as an interactive web page and in PDF format

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance *plus* any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

The Important Questions Chart

Information on:

- Deductible(s)
- Out-of-pocket limits
- Provider networks
- Referral requirements, if any

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?		

The Important Questions Chart: Example

- Question
- Answer
- Why this question matters

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/.

Knowledge Check #3

What information is in the Important Questions Chart?

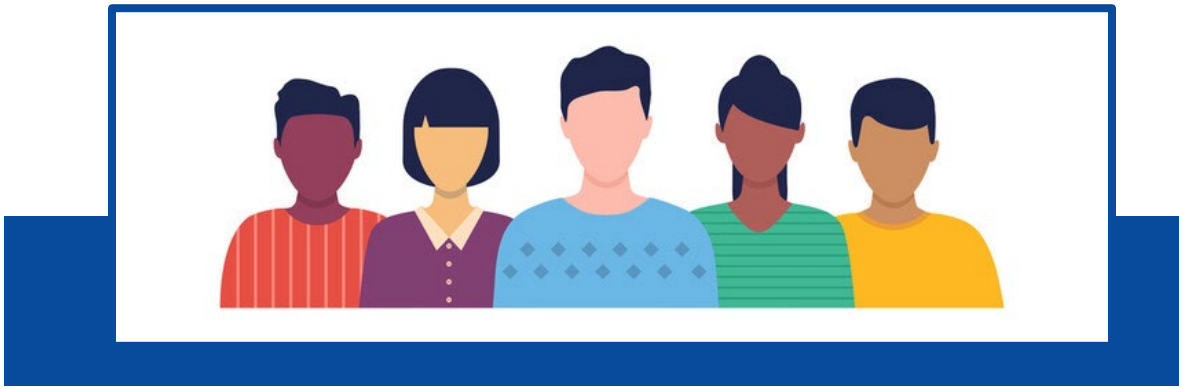
A. Deductibles

B. Out-of-pocket limits

C. Premiums

D. Referral requirements, if any

E. A, B, and D



Knowledge Check #3 Answer

What information is in the Important Questions Chart?

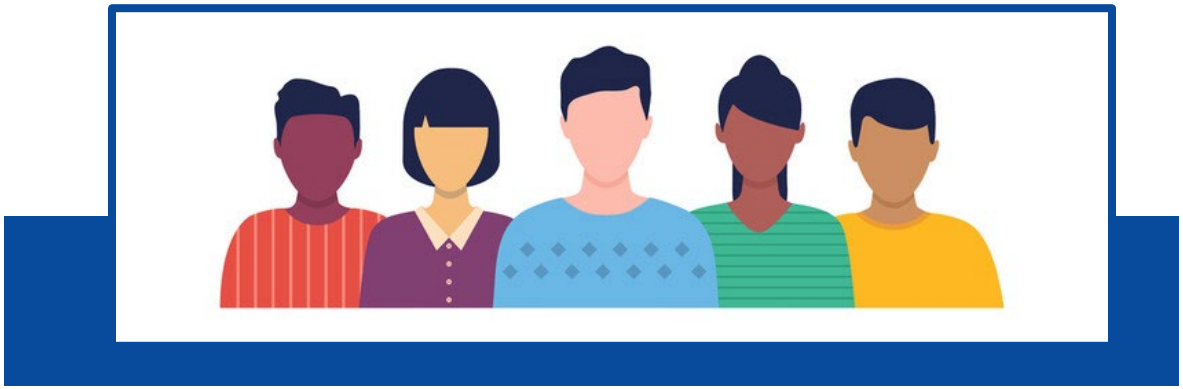
A. Deductibles

B. Out-of-pocket limits

C. Premiums

D. Referral requirements, if any

E. A, B, and D



The Common Medical Events Chart

If you:

- Visit a health provider
- Have a test
- Need drugs to treat your illness or condition
- Have outpatient surgery
- Need immediate medical attention
- Have a hospital stay
- Need mental health, behavioral health, or substance abuse services
- Are pregnant
- Need help recovering or have other special health needs
- Have a child who needs dental or eye care

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			
	Specialist visit			
	Preventive care/screening/ immunization			

Excluded Services & Other Covered Services

- List of items and services that are either excluded from coverage or are covered under the terms of the plan
- Consumers should refer to plan or policy documents for a complete list of the services the plan covers

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic Surgery • Dental Care • Infertility Treatment	• Long Term Care • Non-emergency care when traveling outside the U.S. • Private Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care

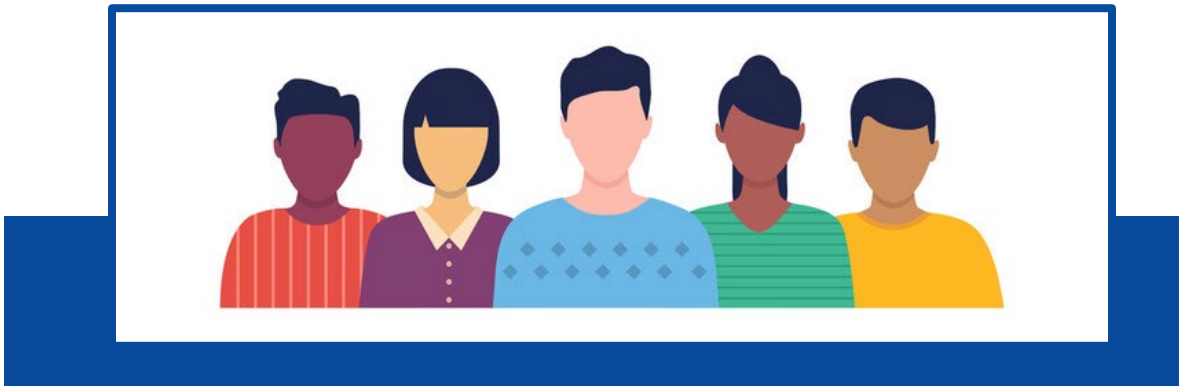
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (if prescribed for rehabilitation)	• Chiropractic Care	• Weight Loss Programs

*This is a hypothetical example and does not represent an actual plan available for coverage.

Knowledge Check #4

The Common Medical Events chart only lists cost-sharing information for in-network providers and instructs consumers to refer to plan or policy documents for information about cost sharing for out-of-network providers.

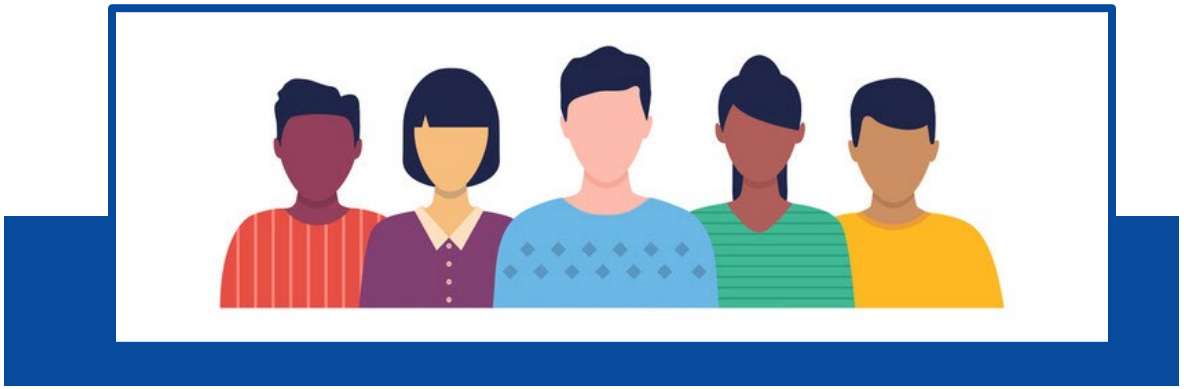
True or False?



Knowledge Check #4 Answer

The Common Medical Events chart only lists cost-sharing information for in-network providers and instructs consumers to refer to plan or policy documents for information about cost sharing for out-of-network providers.

False



The Disclosures: Your Rights to Continue Coverage

- Appropriate agency to contact for more information about continuing coverage after policy ends
- Link to HealthCare.gov

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

The Disclosures: Your Grievance and Appeals Rights

Contact information and instructions for:

- Appealing certain decisions made by the consumer's health plan
- Making a complaint against the plan

Your Grievance and Appeals Rights: 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. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

The Disclosures: Does This Plan Provide Minimum Essential Coverage?

- Discloses whether the plan qualifies as minimum essential coverage (MEC).

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.

- All Marketplace plans and most employer-sponsored health plans provide MEC. Additional coverage that qualifies as MEC includes Medicare, most Medicaid coverage, the Children's Health Insurance Program (CHIP), and Tricare. For more information on types of health coverage that count as MEC, visit Minimum Essential Coverage in the Uniform Glossary.

The Disclosures: Does This Plan Meet the Minimum Value Standards?

- Discloses whether the plan meets minimum value standards.

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

- Minimum value = designed to pay at least 60 percent of the total allowed costs of benefits for a standard population, and benefits include substantial coverage of physician and inpatient hospital services.
- Consumers whose employer-sponsored coverage is unaffordable or does not meet minimum value standards may be eligible for premium tax credits (if otherwise eligible).

The Disclosures: Language Access Services

- The SBC must include language access taglines that indicate the availability of language services.
- For QHPs: Provide taglines in at least the top 15 languages spoken by individuals with Limited English Proficiency in the relevant state; and
- **For all group health plans and health insurance issuers offering group and individual health insurance coverage:** Provide taglines in a particular non-English language if 10 percent or more of the population residing in the county is literate only in that same non-English language.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

Coverage Examples

- Hypothetical examples: Pregnancy, Type 2 diabetes, simple fracture
- Illustrate benefits to estimate what an individual might expect to pay under the plan's benefit package
- Include any cost sharing, excluding benefits, and other limitations for hypothetical examples

Coverage Examples (Cont.)

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$	■ The plan's overall deductible	$	■ The plan's overall deductible	$
■ Specialist copayment	$	■ Specialist copayment	$	■ Specialist copayment	$
■ Hospital (facility) coinsurance	%	■ Hospital (facility) coinsurance	%	■ Hospital (facility) coinsurance	%
■ Other coinsurance	%	■ Other coinsurance	%	■ Other 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)*		**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)*		**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	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$	Deductibles	$	Deductibles	$
Copayments	$	Copayments	$	Copayments	$
Coinsurance	$	Coinsurance	$	Coinsurance	$
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$	Limits or exclusions	$	Limits or exclusions	$
The total Peg would pay is	**$**	**The total Joe would pay is**	**$**	**The total Mia would pay is**	**$**

Resources

- CMS.gov:
  - SBC Materials and Supporting Documents
  - SBC Regulations, Guidance and Other Materials
  - Uniform Glossary (PDF)
- HealthCare.gov:
  - Health Insurance Rights and Protections: Summary of Benefits and Coverage
  - Glossary of Health Coverage and Medical Terms
- CMS.gov/marketplace:
  - The Health Insurance Marketplace: Know Your Rights
  - Summary of Benefits and Coverage Job Aid