

FACT SHEET #1

Comparing Health Plans' Benefits and Coverage Summaries

This fact sheet is intended to help Navigators answer specific questions that people with disabilities might ask about benefits and coverage available through the Health Insurance Marketplace

Q1. What is the "Summary of Benefits and Coverage (SBC)"?

A. All individual and group health plans participating in the Marketplace must use the same standard form, called "Summary of Benefits and Coverage (SBC)." Plans offered outside the Marketplace either through an employer or as individual coverage must also use the same standard form SBC. The standard form is an easy-to-understand, plain language summary about a health plan's benefits and coverage. This information allows you to compare coverage for specific benefits offered by different plans. The SBC also includes details, called coverage examples, which allows you to see what the plan would cover in two common medical situations: diabetes care and childbirth.

Q2. Why do I need to look at health plans' summaries of benefits and coverage, and what do I need to find out from them?

A. Most consumers will want to know what healthcare benefits are available to them from health plans they are considering purchasing, along with the cost of these services. As a person with a disability, however, you might have more foreseeable, specific and possibly unique coverage needs. For this reason, you should look at the SBCs and compare available benefits and related costs among the health plans you are considering purchasing.

Q3. Is an example of the SBC available?

A. Yes. A sample of the SBC form can be found at: <https://www.cms.gov/CCIIO/Resources/Files/Downloads/sbc-sample.pdf>. A glossary of terms is also at: <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html>)

Q4. Is a summary of benefits and coverage available for each of the health plans I might be interested in purchasing through the Marketplace?

A. Yes. A link to the SBC for each health plan participating in the Marketplace is available on the Marketplace website. (See www.healthcare.gov) Plans available

through an employer or sold outside the Marketplace must also make their SBC available.

Q5. Does the SBC provide information about deductibles and the out-of-pocket limits available for the plans I might be considering?

A. Yes. The SBC provides information about overall deductibles and out-of-pocket limits for each plan. For example, the SBC might say that the out-of-pocket limit for health care providers who participate in a particular plan is \$2500 for individuals and \$5000 for families.

Q5a. Why is this information important to me?

A. Some people with disabilities might want to calculate their annual out-of-pocket expenses for the plans they are considering separate from the calculation of copayments or coinsurance for specific services in order to determine which plan will be best for them when these combined costs are considered. If you or someone else in your family who is covered by the plan is likely to require particular healthcare services frequently or in a significant amount because of health conditions you now have, then your out-of-pocket expenses will be an important factor in your choice of plans. As another example, you might also want to know what your out-of-pocket expense will be for a visit to a provider who does not participate in your chosen plan's network in the event you need to visit a particular specialist.

Q6. Does the SBC say whether or not the plan uses a network of providers?

A. Yes. The SBC says whether or not the plan uses a network of providers, whether the plan pays for services received from an out-of-network provider, and how your share of the costs for visits to out-of-network providers may be different from your share of the costs for care provided by network providers. It might also provide a website address or telephone number where a list of participating providers can be obtained. If this is not the case, I can help you to contact a plan to get more information about a plan's provider network.

Q6a. Why is this information important to me?

A. If you or a family member has long-standing relationships with certain medical providers, you will likely want to know if those providers participate in the networks of the health plans you are considering. You might also want to know if the plan has particular specialty or service providers known to have knowledge or awareness of your specific disability or those of your family members.

Q7. Does the SBC say what the copayment or coinsurance will be for visits to specific providers and for diagnostic tests and procedures?

A. Yes. The SBC will say what the copayment or coinsurance will be for a visit to a primary care physician and a specialty physician or other practitioner. For example, in plans that charge a copayment (fixed dollar amount) for a visit or service, a visit to a primary care physician may cost \$35 while a visit to a specialist might cost \$50. In plans that charge coinsurance (your charge is a percentage of the plan's allowed payment amount) for a visit or service, a visit to a primary care physician may cost 20% of the allowed amount while a visit to a specialist might cost 30% of the allowed amount. The SBC will also say what the copayment or coinsurance will be for a diagnostic test such as blood work or an x-ray.

Q8. Does the SBC say what the copayment or coinsurance will be for prescription drugs?

A. Yes. The SBC will say what the copayment or coinsurance will be for generic drugs. For example, there may be a \$10 copayment for generic prescription medication. On the other hand, your share of the cost for a preferred brand drug might be a coinsurance payment of 20%. So, for example, your 20% coinsurance payment for a brand drug costing \$200 would be \$40.

Q9. Does the SBC say what your costs will be for services such as mental or behavioral health inpatient and outpatient services, and substance use disorder inpatient and outpatient services?

A. Yes. The SBC will say what your share of the cost will be for such services. For example, the services might require you to pay a \$35 copayment per office visit or a 20% coinsurance payment.

Q9a. Why is this information important to me?

A. It likely will be important for you to determine, to the extent possible, what your actual out-of-pocket costs will be for the healthcare services you or your family requires. For example, if you or they require regular physician visits, access to specific medications, or ongoing mental or behavioral health or substance use disorders services, affordability will be a central concern for you. Thus, you will want to know what the cost of the services will be, to the extent possible, in advance of purchasing a particular health insurance policy. You will also want to take these costs into consideration along with the out-of-pocket cost of monthly insurance premiums and deductibles.

Q10. Does the SBC say what the cost will be for services such as home health care, habilitation services, rehabilitation services, or durable medical equipment?

A. The SBC says what the flat dollar amount copayment or the percentage of coinsurance will be for these services. However, in order to calculate the out-of-pocket expense when a coinsurance payment is required, you will need to contact the plan directly to determine how much it will pay for the specific service in order to determine the out-of-pocket percentage that will be required as a coinsurance payment. For example, if the plan charges a 30% coinsurance amount for durable medical equipment, you would want to know what the plan pays for the equipment you need. For example, if the plan charges \$10,000 for complex rehabilitation technology such as a motorized wheelchair and the coinsurance payment is 30%, then your out-of-pocket cost for this device will be \$3000.

Q10a. Why is this information important to me?

A. Access to durable medical equipment such as complex rehabilitation technology (medically necessary, individually configured manual and power wheelchair systems) and services such as occupational, physical, and speech therapy might be essential to ensuring your health and well-being and support your ability to participate fully in your community. It will be important, therefore, for you to compare how much the services will cost annually across the various plans you are considering.

Q11. Will the SBC tell me if any of the benefits have annual or lifetime limits or special conditions?

A. The Affordable Care Act (ACA) does not allow such limits after January 1, 2014. However, the benchmark plans some states have chosen to guide the benefits and services offered by plans available through the Marketplace might contain such limits for certain benefits or services (e.g., durable medical equipment). They might also contain limits on the number of visits you may receive for a particular service. In turn, these limits might be reflected in the SBC of plans you are considering. You will need to contact the plan directly to learn more about how it hopes to reconcile any contradictions and what these restrictions, if any exist, will mean for you.

Q12. Does the SBC say what services are excluded?

A. The SBC provides a partial list of services that the plan does not cover. For example, services such as adult dental care, infertility treatment, long-term care, or cosmetic surgery might not be covered. However, because the list of services that are not covered might be incomplete, you should contact the plan directly

and ask for a list of all of the services that the plan does not cover. This extra step is important so you can know with certainty if any services that you need now or think you might need in the future are also excluded. You will need this information in order to make an informed purchase decision.

Q13. Does the SBC provide information about grievance and appeals rights?

A. The SBC provides a point of contact if you have a complaint or are dissatisfied with a denial of coverage for claims under the plan. You might need to contact a particular plan if you wish to know a plan's particular grievance, complaint and appeal procedures in advance of purchase. Typically, you can appeal a health plan's decision in two ways. If your claim is denied, you have the right to an internal appeal. You may ask your insurance company to conduct a full and fair review of its decision. If your case is urgent, your insurer must speed up the process. You also have the right to take your appeal to an independent third party for review, called an external review. External review means that the insurance company no longer gets the final say over whether to pay a claim.

The Marketplace and your state might also have relevant information about grievance or appeal procedures.

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