ConsumersUnion
POLICY & ACTION FROM CONSUMER REPORTS

SBC FACT SHEET
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Requirements for Providing the Summary of Benefits and Coverage Form

SUMMARY

This fact sheet explains the federal requirement for health plans to provide a Summary of Benefits and Coverage (SBC) form describing the provisions of the plan. The fact sheet explains when the forms are required, what kinds of plans must provide them, and what information must be included in an SBC. Early experience with these forms suggests that health plans are not fully complying with all requirements. We hope that this additional clarity will help consumers and advocates exercise their rights to this information.

Under the Affordable Care Act (ACA), health insurers and group health plans must provide shoppers and enrollees with a Summary of Benefits and Coverage form (SBC) and a glossary of terms commonly used in health care coverage.[1] The goal of the SBC is to help consumers gain a better understanding of the coverage offered by the plan by providing a uniform method of displaying information about covered services and benefits.

Why should consumers care about the Summary of Benefits and Coverage?

The Summary of Benefits and Coverage (SBC) is an important tool that consumers can use to compare the benefits and costs of different insurance plans. Full health care contracts are typically long and hard to understand.2 The SBC's condensed format makes it easier to find the important information without pouring over a lengthy contract. Moreover, the information is formatted in the same way for all health plans, making it easier to compare across insurers and even across markets (for example, compare a non-group plan to an employer plan). This uniform format is designed to highlight the important facts, like co-payments levels and overall deductible.

What is required to be in the Summary of Benefits and Coverage?

The ACA requires the SBC to include:

- A description of the coverage offered by the plan.
- Exceptions, reductions, or limitations of the plan.
- Cost-sharing provisions including the amount of any deductible or limitations of the plan, as well as co-insurance and co-payment obligations.
- Renewability and continuation of coverage provisions.
- Coverage examples showing how the plan covers certain services.
- A statement that the SBC is only a summary and that the plan should be consulted to determine the participant's contractual obligations.
- The issuer's contact information.

What's missing from the SBC?

Other information that consumers should consider when selecting a plan, but are not included in the SBC, are premiums, health savings accounts (HSAs), flexible savings arrangements (FSAs), and additional details about provider networks and drug formularies.

Which Plans Are Required to Provide the SBC?

Most private insurance plans offered in the United States must provide an SBC free of charge.[3] The SBC has to be provided for:

- Individual medical policies, including plans offer inside and outside the new Marketplaces, regardless of whether the plan is new or existed before the ACA went into effect;
- Employer-provided plans, including both fully-insured and self-insured plans, regardless of grandfathered status; and
- International policies for coverage in the United States.

The SBC is the only document that provides a description of coverage using a common format across all these types of plans.

An SBC is not required for stand-alone dental plans, Medicare, or Medicaid.

When should consumers expect a Summary of Benefits and Coverage?

Health plans are required to provide an SBC when it is most useful to consumers--when they are shopping for or enrolling in coverage. An SBC must be provided:

- At the time of application for insurance;
- Within seven business days of a consumer's request; and
- Annually at renewal for existing enrollees.

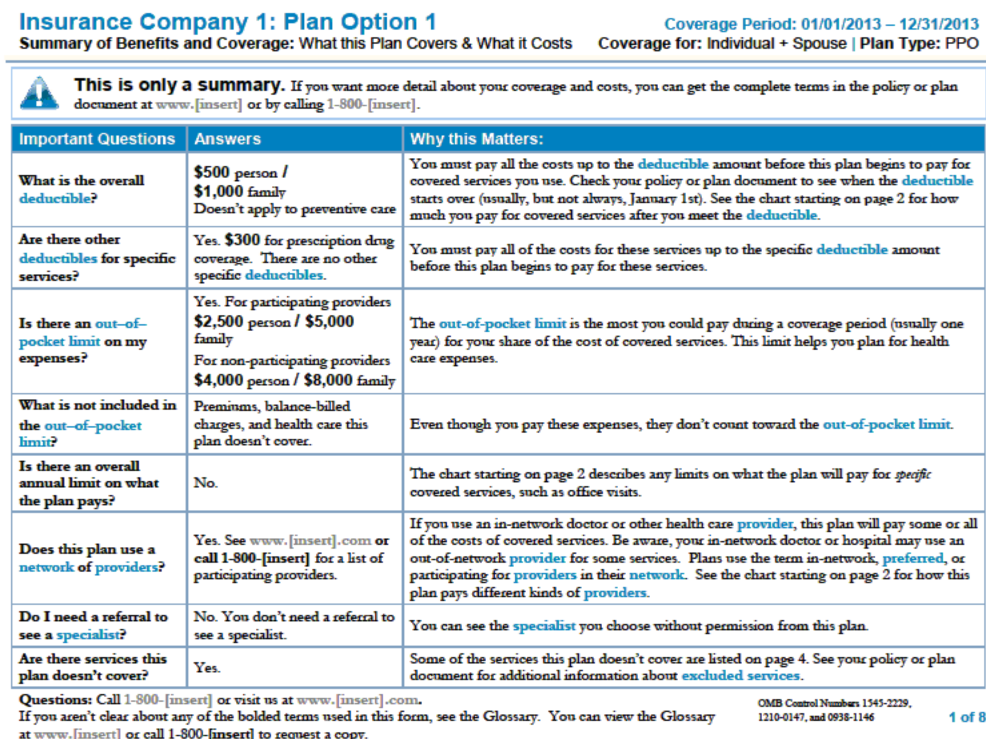
An issuer may choose to provide the SBC online. If using this method, the health plan must advise that it is available online and provide a link to it. If the SBC is provided online, the issuer is also required to make it available in paper form, free of charge upon request.

Some Marketplaces, including the Federally-facilitated Marketplace at www.healthcare.gov, make SBCs available online through their Exchange websites.

What does a Summary of Benefits and Coverage look like?

The SBC must be a stand-alone document. All SBCs must use a uniform format and must use language understandable by the average consumer. Page 1 from a typical SBC is shown in Exhibit 1 below.

<u>EXHIBIT 1:</u> SAMPLE FRONT PAGE OF THE SUMMARY OF BENEFITS AND COVERAGE



Insurance Company 1: Plan Option 1 — Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs — **Coverage for:** Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific deductibles.	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.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.[insert].com or call 1-800-[insert] for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-[insert] or visit us at www.[insert].com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 — 1 of 8

Plans and issuers must provide an SBC that is culturally and linguistically appropriate. The standard for providing an SBC in a non-English language applies when 10% or more of a county's population speaks a specific language.[4]

In addition to providing SBCs in languages other than English, issuers must give notice of the availability of language assistance and provide translation upon request in certain limited languages.

What are the coverage examples?

Coverage examples are required to be included in an SBC typically around page 6. They are new, comparative tools that show what expenses the plan would cover in two common medical situations—having a baby and managing type 2 diabetes for a year. Insurers assume the same provider charges[5] and then calculate the amount the plan how these charges would be split between the patient and the plan. The examples show how much is left for the consumer to pay due to the plan's deductibles, co-payments, and co-insurance provisions, assuming no other medical expenses for the year. Not all consumers are aware of these examples[6] but once known, they proved very helpful to consumers to understand how the plan's cost-sharing provisions work.[7]

<u>EXHIBIT 2:</u> SAMPLE COVERAGE EXAMPLES

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,490
- **Patient pays** $2,050

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$700
Copays	$30
Coinsurance	$1320
Limits or exclusions	$0
Total	**$2,050**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,520
- **Patient pays** $1,880

Sample care costs:

Prescriptions	$2,90(
Medical Equipment and Supplies	$1,30(
Office Visits and Procedures	$70(
Education	$30(
Laboratory tests	$10(
Vaccines, other preventive	$10(
Total	**$5,40(**

Patient pays:

Deductibles	$80(
Copays	$50(
Coinsurance	$50(
Limits or exclusions	$8(
Total	**$1,88(**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [insert]

Source: http://www.dol.gov/ebsa/pdf/SBCtemplate.pdf

What if a consumer didn't receive a Summary of Benefits and Coverage?

You have a right to this document. Call the health plan first to request the document. Health plans often offer more than one type of summary of their benefits, so insist on the SBC formatted version so the consumer can easily compare across products. If the consumer buys insurance on his or her own and the issuer does not provide the form, contact your state's insurance department.8 If the consumer gets insurance through an employer, contact their employee benefits department.

If your SBC contains errors or inconsistencies, use the same process to notify the appropriate entity.

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ENDNOTES

[1] The glossary document does not vary from plan to plan and can be downloaded here: http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf

[2] *How Readable Are Summary Plan Descriptions For Health Care Plan?* Employee Benefit Research Institute, October 2006, Vol. 27, No. 10.

[3] Regulation on when and how to provide: http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf#page=2

[4] 26 CFR §54.9815-2715(a)(5).

[5] Total costs are based on Medicare payment rates. As such, they may be lower than the provider payment rates negotiated by private plans.

[6] L. Quincy, *Early Experience with a New Consumer Benefit – the Summary of Benefits and Coverage*, Consumers Union, February 2013.

[7] Consumers Union and Kleimann Communication Group, *Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Plans*, August 2011 and America's Health Insurance Plans [and] Blue Cross Blue Shield Association Focus Group Summary, JKM Research, May 2011.

[8] You can find your state insurance department using this link: http://www.naic.org/state_web_map.htm