

Summary of Benefits and Coverage (SBC) Training

Oregon Insurance Division and Cover Oregon
June 12, 2014

SBC Purpose

- ▶ PHSA 2715 generally requires all health plans to provide applicants, enrollees, and policyholders or certificate holders with an accurate summary of benefits and coverage.
- ▶ It is a market-wide requirement, regardless of exchange participation.

SBC Review this year

- ▶ Last year, Cover Oregon reviewed the SBCs.
- ▶ This year, OID will be performing an audit of the SBCs.

SBC General Information

- ▶ All of the information included in the SBC must match the cost shares and benefits approved on the benefit summary in the form filing and what is listed for that plan in the Plan and Benefits template.
- ▶ Provide one SBC for each plan submitted within the binder. *If there are 30 plans submitted, please submit 30 SBCs.*
- ▶ No ZIP files are allowed; individual PDFs of each plan should be attached.
- ▶ **These must be uploaded into the binder by August 15.**

SBC General Information

- ▶ The plan name must exactly match what was entered on the Plan and Benefits template. For example, Acme's Super Silver plan should also be listed as "Super Silver" on the SBC, not "Super 2500 Silver" or "Super Duper Silver 2000".
- ▶ Check that page numbers are accurately listed. For example, correct items like "Page 10 of 8".
- ▶ If changes are made to the plans throughout binder review, the affected SBCs must also be updated.
- ▶ SBCs must be created for **all** plan variants, including Tribal plans.
- ▶ Be very clear on what the deductible applies to.

Oregon-Specific SBC Requirements

These requirements will be discussed at the next Industry Communication meeting on Wednesday, June 19, and specific details for implementing these requirements will follow.

- ▶ **Abortion services:** All health insurers offering individual health benefit plans must disclose what abortion services, if any, each plan covers. This is a market-wide requirement to ensure consumer information at the time of shopping and enrollment. This will also meet the federal and state requirements for disclosure of abortion services coverage in 45 CFR 156.280 and OAR 836-011-0050.
- ▶ **Preventive services with zero cost share:** All health insurers offering individual and small group health benefit plans must provide a detailed list of certain preventive health services not subject to cost-sharing.
- ▶ Please note that some of the services the SBC instructions describe as excluded services are required to be covered in Oregon—cosmetic surgery (in certain situations), hearing aids (required for children), and routine foot care (required for diabetics). *(These items are also listed on Slide 43.)*

SBC General Instructions

- ▶ Unless otherwise instructed, the issuer must use 12-point font—in both individual and group filings (as required by Federal law)—and replicate all symbols, formatting, bolding, and shading.
- ▶ Also, Oregon law also requires that all individual policy documents are in 12-point font this year per ORS 743.405(5)(a); this font requirement is not applicable to group.
 - *ORS 743.405(5)(a) Except as provided in ORS 743.498, the style, arrangement and overall appearance of the policy may not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any indorsements or attached papers shall be plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than 12-point type.*

SBC General Instructions

- ▶ 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 or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program.

SBC General Instructions

- ▶ Issuers must customize all identifiable company information throughout the document, including websites and telephone numbers.
- ▶ The items shown on page 1 must always appear on page 1, and the rows of the chart must always appear in the same order.
- ▶ The chart starting on page 2 must always begin on page 2, and the rows shown in this chart must always appear in the same order. However, the chart rows shown on page 2 may extend to page 3 if space requires, and the chart rows on page 3 may extend to the beginning of page 4 if space requires.
- ▶ The Excluded Services and Other Covered Services section may appear on page 3 or page 4, but must always immediately follow the chart starting 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, and the Coverage Examples section, in that order.
- ▶ The footer must appear at the bottom left of every page. The issuer must insert the appropriate telephone number and website information.
- ▶ Specific Oregon form numbers are not required on SBCs, as they are not required to be filed in form filings but only submitted for binder filings.

SBC General Instructions

- ▶ For all form sections to be filled out by the issuer, plain language should be used.
- ▶ For questions about completing the SBC, contact SBC@cms.hhs.gov.

Filling out the form – Page 1

Top Left Header: _____: _____
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

- ▶ On the top left hand corner of the first page, the issuer must show the following information:
 - First line: Show the plan name and insurance company name in 16 point font and bold. Example: **“Maximum Health Plan: Alpha Insurance Group”**.
- ▶ The issuer must use the commonly known company name.
- ▶ This is where the standard plans must list the naming convention required by rule:
 - **[Name of issuer] Oregon Standard [Bronze/Silver] Plan**

Filling out the form – Page 1

Top Right Header: Coverage Period: [See Instructions]
Coverage for: _____ | Plan Type: _____

- ▶ On the top right hand corner of the first page, the issuer must show the following information:
 - **First line:** After Coverage Period, the issuer must show the beginning and end dates for the applicable coverage period (such as policy year) in the following format: “MM/DD/YYYY – MM/DD/YYYY”. For example: “Coverage Period: 01/01/2013 – 12/31/2013”.
 - **Second line:** After Coverage for, indicate who the coverage is for (such as Individual or Family). The issuer should use the terms used in the policy documents.
 - After Plan Type, indicate the type of coverage, such as PPO, POS, or High-deductible.

Filling out the form – Page 1



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.\[insert\]](http://www.[insert]) or by calling 1-800-[insert].

- ▶ The disclaimer at the top of page 1 should be replicated and the issuer may not vary the font size, graphic, or formatting. The issuer should insert a website and telephone number for accessing or requesting copies of the policy documents. The issuer should also include a website and telephone number for accessing or requesting copies of the Uniform Glossary.
- ▶ The Uniform Glossary can be accessed at: www.cciio.cms.gov. This Internet address may be used as the website designated for obtaining the Uniform Glossary.)

Important Questions chart – General Instructions

Important Questions

Answers

Why this Matters:

- ▶ This chart must always appear on page 1, and the rows must always appear in the same order. Issuers must complete the Answers column for each question on this chart.
- ▶ Issuers must show the appropriate language in the Why This Matters box. Issuers must replicate the language given for the Why This Matters box exactly, and may not alter the language.

Important Questions chart – General Instructions

Important Questions

Answers

Why this Matters:

- ▶ If there is a different amount for in-network and out-of-network expenses (such as annual deductible or out-of-pocket limits), list both amounts and indicate as such, using the terms to describe provider networks used by the issuer.
- ▶ For example, if the policy uses the terms “preferred provider” and “non-preferred provider” and the annual 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”.

Important Questions / Answers / Why This Matters Chart

| Important Questions | Answers |
|---------------------------------|---------|
| What is the overall deductible? | \$ |

- ▶ **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.
 - If there is an overall deductible, underneath the dollar amount, issuers must include language specifying major categories of covered services that are NOT subject to this deductible. **For example, for standard silver plans: “Does not apply to preventive care, urgent care, office visits, and prescription drugs”.**
 - If there is an overall deductible, underneath the dollar amount issuers must include language listing major exceptions, such as out-of-network co-insurance, deductibles for specific services and copayments, which do not count toward the deductible. **For example, “Out-of-network co-insurance and copayments don’t count toward the deductible.”**
 - 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, “\$2,000 person / \$3,000 family”).

Important Questions / Answers / Why This Matters Chart

| Important Questions | Answers | Why this Matters: |
|---------------------------------|---------|-------------------|
| What is the overall deductible? | \$ | |

What is the overall deductible?

- ▶ **Why this matters column:**
- ▶ If there is no overall deductible, show the following language: “See the chart starting on page 2 for your costs for services this plan covers.”
- ▶ If there is an overall deductible, show the following language: “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.”

Important Questions / Answers / Why This Matters Chart

| | |
|--|----|
| Are there other deductibles for specific services? | \$ |
|--|----|

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. Examples of other deductibles include deductibles for Prescription Drugs. For example: “Yes, \$2,000 for prescription drug expenses”.
- 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 -- Individual \$200, Family \$500”

Important Questions / Answers / Why This Matters Chart

| | | |
|--|----|--|
| Are there other deductibles for specific services? | \$ | |
|--|----|--|

Are There Other Deductibles for Specific Services?:

▶ Why This Matters column:

- If there are no other deductibles, the issuer must show the following language: “You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.”
- If there are other deductibles, the 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.”

Important Questions / Answers / Why This Matters Chart

Is there an out-of-pocket limit on my expenses?

\$

Is There An Out-of-Pocket Limit On My Expenses?:

- ▶ **Answers column:**
- ▶ All plans in Oregon have out-of-pocket limits.
- ▶ Respond “Yes”, along with a specific dollar amount that applies in each coverage period. For example: “Yes. \$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, “Individual \$1,000 / Family \$3,000”).
- ▶ If there are separate out-of-pocket limits for in-network providers and out-of-network providers, show both the in-network OOP limit and the out-of-network OOP limit. Issuers should use the terminology as listed in the policy documents. For example: “For participating providers \$2,500 person/\$5,000 family; for non-participating providers \$5,000 person/\$10,000 family”

Important Questions / Answers / Why This Matters Chart

Is there an out-of-pocket limit on my expenses?

\$

Is There An Out-of-Pocket Limit On My Expenses?:

▶ Why This Matters column:

- Since there is an out-of-pocket limit, the issuer must show the following language: “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.”

Important Questions / Answers / Why This Matters Chart

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

What Is Not Included In The Out-of-Pocket Limit?:

▶ Answers column:

- The issuer must list any major exceptions to the out-of-pocket limit. This list must always include the following three terms:
 - Premiums
 - Balance-billed charges
 - Health care this plan doesn't cover
- The list could also include: copayments, out-of-network coinsurance, deductibles, and penalties for failure to obtain pre-authorization for services. The issuer must state that these items do not count toward the limit. For example: "Copayments, premiums, balance-billed charges, and health care this plan doesn't cover."

Important Questions / Answers / Why This Matters Chart

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

What Is Not Included In The Out-of-Pocket Limit?:

▶ Why This Matters column:

- If there is an out-of-pocket limit, the issuer must show the following language: “Even though you pay these expenses, they don’t count toward the out-of-pocket limit.”

Important Questions / Answers / Why This Matters Chart

Is there an overall annual limit on what the plan pays?

Is There An Overall Annual Limit On What The Plan Pays?:

▶ Answers column:

- The policy should not have an overall annual limit and the issuer should state, “No.”

▶ Why This Matters column:

- If there is no overall annual limit, the issuer must show the following language: “The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.”

Important Questions / Answers / Why This Matters Chart

Does this plan use a network of providers?

Does This Plan Use A Network of Providers?: Answers column:

- ▶ If the plan uses a network, the issuer must respond, “Yes,” and include information on where to find a list of preferred providers or in-network providers, etc. For example: “Yes. For a list of preferred providers, see [www.\[insert\].com](http://www.[insert].com) or call 1-800-[insert].” Issuers should use the terminology in the policy or plan document (e.g., in-network, participating, or preferred).

Important Questions / Answers / Why This Matters Chart

Does this plan use a network of providers?

Does This Plan Use A Network of Providers?:

▶ Why This Matters column:

- If this plan uses a network, the issuer must show the following language:
 - “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.”

Important Questions / Answers / Why This Matters Chart

Do I need a referral to see a specialist?

Do I Need a Referral To See A Specialist?:

▶ Answers column:

- Issuers should use plan-specific language with respect to specialists. For example, distinguishing between preferred and non-preferred specialist or in-network and out-of-network specialists.
- Issuers should specify whether written or oral approval is required to see a specialist.
- Issuers should specify whether specialist approval is different for different plan benefits.

Important Questions / Answers / Why This Matters Chart

Do I need a referral to see a specialist?

Do I Need a Referral To See A Specialist?:

▶ Why This Matters column:

- If there is a referral required, the 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 the plan’s permission before you see the specialist.”
- If there is no referral required, the issuer must show the following language:
 - “You can see the specialist you choose without permission from this plan”.

Important Questions / Answers / Why This Matters Chart

Are there services this plan doesn't cover?

Are there services this plan doesn't cover?:

▶ Answers column:

- Issuer should answer "Yes".

▶ Why This Matters column:

- If there are no excluded services shown in the Services Your Plan Does Not Cover box on page 3 or 4, then the issuer must show the language:
 - "See your policy or plan document for information about excluded services."
- If there are excluded services shown in the Services Your Plan Does Not Cover box on page 3 or 4, then the issuer must show the language:
 - "Some of the services this plan doesn't cover are listed on page [3 or 4]. See your policy or plan document for additional information about excluded services." The issuer should insert the correct page (3 or 4) depending on where the Services Your Plan Does Not Cover box appears on the form.

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Cost Sharing Information Box:

- ▶ The first three bullets in the information box at the top of page 2 should be replicated with the same text, formatting, graphic, bolded words, and bullet points. Only the fourth bullet may change.
- ▶ The fourth bullet will change depending on the plan:
 - For plans that use a network, the issuer should fill in the blank on the fourth bullet of the template, using the terminology that the issuer uses for “in-network” or “preferred provider”. This should be the same term as used in the heading of the first sub-column under the Your Cost column.
 - For non-networked plans, the issuer should delete the fourth bullet and replace it with: “Your cost sharing does not depend on whether a provider is in a network.”

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|----------------------|-----------------------|---|---|--------------------------|
|----------------------|-----------------------|---|---|--------------------------|

Chart Starting on page 2:

▶ Location of Chart:

- This chart must always begin on page 2, and the rows shown on pages 2 and 3 must always 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.

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions

| Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider |
|--|--|
|--|--|

Your Cost columns:

- ▶ Issuers may vary the number of columns depending upon the type of policy and the number of preferred provider networks. Most policies that use a network should use two columns, although some policies with more than one level of in-network provider may use three columns. Non-networked plans may use one column.
- ▶ Issuers should insert the terminology used in the policy to title the columns. For example, the columns may be called “In-network” and “Out-of-network”, 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.

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions

| Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider |
|--|--|
|--|--|

Your Cost columns:

- ▶ 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) “In-Network Preferred Provider,” “In-Network Provider,” and then “Out-of-Network Provider.”
- ▶ For plans providing no out-of-network benefits, the issuer should insert “Not covered” in all applicable boxes under the far-right sub-heading under the Your Cost column (which, for policies providing out-of-network benefits, would usually be out-of-network provider or non-preferred provider column).

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions

| Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider |
|---|---|
|---|---|

Your Cost columns:

- ▶ Issuers must complete the responses under these sub-headings based on how the issuer covers the specific services listed in the chart. Fill in the Your Cost column(s) with what the consumer pays: the co-insurance percentage, the co-payment amount, “No charge” if the consumer pays nothing, or “Not covered” if the service is not covered by the plan. When referring to co-insurance, include a percentage valuation. For example: 20% co-insurance. When referring to co-payments, include a per occurrence cost. For example: \$20/visit or \$15/prescription.
- ▶ Refer to the specific additional instructions below for details on completing the Your Costs 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 have mental health, behavioral health, or substance abuse needs.

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions

Limitations & Exceptions

Limitations & Exceptions column:

- ▶ In this column, list the significant limitations and exceptions for each row. Significance of limitations and exceptions is determined by the issuer based on two factors: probability of use and financial impact on the consumer. Examples include:
 - limits on the number of visits
 - prior authorization requirements
 - lack of applicability of a deductible
 - a separate deductible
- ▶ Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows “Coverage is limited to \$XX/visit and XX visit max per year.” or “No coverage for XXXX.”

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions

Limitations & Exceptions

Limitations & Exceptions column:

- ▶ If the issuer requires the consumer to pay 100% of a service in-network, then that should be considered an “excluded service” and should appear in the Limitations & Exceptions column and also appear in the Services Your Plan Does Not Cover box on page 3 or 4. Must show these exclusions in both the Limitations & Exceptions column and the Services Your Plan Does Not Cover box.
- ▶ If there are pre-authorization requirements, the issuer must show the requirement including specific information about the penalty for noncompliance.

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions

Limitations & Exceptions

Limitations & Exceptions column:

- ▶ If there are no items that need to appear in the Limitations & Exceptions box for a row, then the issuer should show “---none---”.
- ▶ For each Common Medical Event in the chart, the issuer has the discretion to merge the boxes in the Limitations & Exceptions column and display one response across multiple rows if such a merger would lessen the need to replicate comments and would save space.

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|--|---|---|--------------------------|
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | | | |
| | Specialist visit | | | |
| | Other practitioner office visit | | | |
| | Preventive care/screening/immunization | | | |

Common Medical Events:

If you visit a health care provider's office or clinic:

- ▶ If the issuer covers other practitioners care (which includes chiropractic care and/or acupuncture), in the “Other practitioner office visit” row, the issuer will provide the cost sharing for the other practitioners care in the Your Cost columns. For example, under the in-network column, the issuer may respond “20% co-insurance for chiropractor and 10% co-insurance for acupuncture”.
- ▶ If the issuer does not cover other practitioners care, the issuer will show “Not Covered” in the Your Cost columns for Other Practitioner Office visit.

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions

| | | | | |
|---|---------------------------|--|--|--|
| If you need drugs to treat your illness or condition | Generic drugs | | | |
| | Preferred brand drugs | | | |
| | Non-preferred brand drugs | | | |
| More information about <u>prescription drug coverage</u> is available at www.[insert]. | Specialty drugs | | | |

Common Medical Events:

If you need drugs to treat your illness or condition:

- ▶ Under the Common Medical Events column, provide a link to the website location where the consumer can find more information about prescription drug coverage for this plan. If there is no website, provide a contact phone number where the consumer can receive more information about prescription drug coverage for this policy.
- ▶ Under the Services You May Need column, the issuer should list and complete the categories of prescription drug coverage under the policy (for example, the issuer might fill out 4 rows with the terms, “Generic drugs”, “Preferred brand drugs”, “Non-preferred brand drugs”, and “Specialty drugs”). It is recommended that issuers avoid the term “tiers” and instead use “categories” as it is more easily understood by consumers.
- ▶ Under the Your Cost column, issuers should include the cost sharing for both retail and mail order, as applicable.

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions

Common Medical Events:

If you have outpatient surgery:

| | |
|-----------------------------------|--|
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) |
| | Physician/surgeon fees |

- ▶ 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 column. Significance of such expenses is determined by the issuer based on two factors: probability of use and financial impact on the consumer. For example, an issuer might show that the cost sharing for the physician/surgeon fee row is “20% co-insurance”, but the Limitations & Exceptions might show “Radiology 50% co-insurance”.

If you have a hospital stay:

| | |
|--------------------------------|------------------------------------|
| If you have a hospital stay | Facility fee (e.g., hospital room) |
| | Physician/surgeon fee |

- ▶ 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 column. Significance of such expenses is determined by the issuer based on two factors: probability of use and financial impact on the consumer. For example, an issuer might show that the cost sharing for the facility fee row is “20% co-insurance”, but the Limitations & Exceptions might show “Anesthesia 50% co-insurance”.

Common Medical Event, Services, Cost Sharing, Limitations, & Exceptions

If you have mental health, behavioral health, or substance abuse needs

Mental/Behavioral health outpatient services

Mental/Behavioral health inpatient services

Substance use disorder outpatient services

Substance use disorder inpatient services

Common Medical Events:

If you have mental health, behavioral health, or substance abuse needs:

- ▶ If the cost sharing differs for outpatient services for mental/behavioral health needs or substance abuse needs depending on whether the services are office visits or are other outpatient services, show the cost sharing for each. For example, an issuer might show that the cost sharing for Mental/Behavioral health outpatient services is “\$35 co-pay/visit for office visits and 20% co-insurance other outpatient services”.

Disclosures

The following sections must always appear in the order shown:

Excluded Services & Other Covered Services:

Your Rights to Continue Coverage:

Your Grievance and Appeals Rights:

**About these Coverage
Examples:**

The Excluded Services and Other Covered Benefits section may appear on page 3 or page 4 depending on the length of the chart starting on page 2, but it will always follow immediately after the chart starting on page 2.

Excluded Services & Other Covered Services

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

-
-
-

Each issuer must place all services listed below in either the Services Your Plan Does Not Cover box or the Other Covered Services box according to the policy provisions.

The required list of services includes:

- ▶ Acupuncture,
- ▶ Bariatric surgery,
- ▶ Chiropractic care,
- ▶ **Cosmetic surgery**—required for certain situations as covered in the benchmark plan,
- ▶ Dental care (Adult),
- ▶ **Hearing aids**—required for children by mandate ORS 743A.141,
- ▶ Infertility treatment,
- ▶ Long-term care,
- ▶ Non-emergency care when traveling outside the U.S.,
- ▶ Private-duty nursing,
- ▶ Routine eye care (Adult),
- ▶ **Routine foot care**—required for diabetics in the benchmark plan, and
- ▶ Weight loss programs.

Excluded Services & Other Covered Services

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

• • •

The issuer may not add any other benefits to the Other Covered Services box other than the ones listed on the last slide.

However, other benefits may be added to the Services Your Plan Does Not Cover box, as follows:

- ▶ If services appear in the Limitations & Exceptions column in the chart starting on page 2 because the issuer requires the consumer to pay 100% of the service in-network, those services should also appear in the Services Your Plan Does Not Cover box.
- ▶ For example, policies that exclude services in-network, such as pregnancy, habilitation services, prescription drugs, or mental health services, must show these exclusions in both the Limitations & Exceptions column (in the chart starting on page 2) and in the Services Your Plan Does Not Cover box.

Excluded Services & Other Covered Services

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- -
 -
- ▶ List placement **must be in alphabetical order** for each box. The lists **must use bullets** next to each item.
 - ▶ 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/expatriate](http://www.[insert].com/expatriate)"

Excluded Services & Other Covered Services

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

-
-
-

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- - ▶ If the issuer provides limited coverage for any of the services in the previous benefit list, the limitation must be stated in the Services Your Plan Does Not Cover box or the Other Benefits Covered box but not both. For example if an issuer provides acupuncture in limited circumstances, the issuer could choose to include the prescribed statement in the Services Your Plan Does Not Cover box, as follows: "Acupuncture unless it is prescribed by a physician for rehabilitation purposes." Alternatively, the prescribed statement could be in the Other Covered Services box as follows: "Acupuncture if it is prescribed by a physician for rehabilitation purposes."
 - ▶ For example, if an 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 Does Not Cover box would show "Acupuncture, Bariatric Surgery, Dental care (Adult), Habilitation Services, Hearing Aids, Infertility treatment, Long-term care, Non-emergency care when travelling outside the U.S., Private-duty nursing, Routine eye care (Adult), Weight loss programs."

Your Rights to Continue Coverage

Your Rights to Continue Coverage:
[insert applicable information from instructions]

For Individual Plans

This section must appear without alteration, as follows:

“Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- ▶ You commit fraud
- ▶ The insurer stops offering services in the State
- ▶ You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at [contact number]. You may also contact your state insurance department at [insert applicable State Department of Insurance contact information].

Please list the OID contact information, as listed in OAR 836–053–1030(6), except for the website which should be listed as <http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx>

Your Rights to Continue Coverage

Your Rights to Continue Coverage:

[insert applicable information from instructions]

For Group Plans

The following language must appear without alteration, as follows:

- ▶ “If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
- ▶ For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.”

Your Grievance and Appeals Rights

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions].

This section must appear for **Individual Plans**.

- ▶ Contact information should be inserted as follows:
- ▶ Insert applicable State Department of Insurance contact information. **Please list the OID contact information, as listed in OAR 836-053-1030(6), except for the website which should be listed as:**
<http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx>
- ▶ If applicable in your state insert: “Additionally, a consumer assistance program can help you file your appeal. Contact [insert contact information].” Note: A list of states with Consumer Assistance Programs is available at
<http://cciio.cms.gov/prgrams/consumer/capgrants/index.html>.

Your Grievance and Appeals Rights

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions].

This section must appear for **Group Plans**.

- ▶ 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://cciio.cms.gov/programs/consumer/capgrants/index.html>.

Coverage Examples

About these Coverage Examples:

- ▶ HHS will provide all issuers with standardized data to be inserted in the Sample care costs section for the coverage examples. HHS will also provide underlying detail that will allow issuers to calculate Patient pays amounts, including: Date of Service, medical coding information, Provider Type, Category, descriptive Notes identifying the specific service provided, and Allowed Amounts.
- ▶ **The *Amount owed to providers*, also known as the Allowed Amount, will always equal the Total of the *Sample care costs*.** Each issuer must calculate cost sharing, using the detailed data provided by HHS, and populate the *Patient pays* fields. Dollar values are 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 co-insurance amount is estimated at \$57, the issuer would list \$60 in the appropriate *Patient pays* section of the Coverage Examples.

Coverage Examples

About these Coverage Examples:

- ▶ Services on the template are listed individually for classification and pricing purposes to facilitate the population of the Patient pays section. HHS specifies the Category used to roll up detail costs into the Sample care costs categories section. Some plans may classify that service under another category and should reflect that difference accordingly. The issuer should apply their cost sharing and benefit features for each policy in order to complete the Patient pays section, but must leave the Sample care costs section as is. Examples of categories that might differ between the Patient pays and Sample care costs sections could include:
 - 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 issuer must calculate and populate the Patient pays total and sub-totals based upon the cost sharing and benefit features of the plan for which the document is being created. These calculations should be made using the order in which the services were provided (Date of Service).
 - **Deductible** - includes everything the member pays up to the deductible amount. Any co-pays that accumulate toward the deductible are accounted for in this cost sharing category, rather than under co-pays.
 - **Co-pays** - those co-pays that don't apply to the deductible.
 - **Co-insurance** - anything the member pays above the deductible that's not a co-pay or non-covered service. This should be the same figure as the Total less the Deductible, Co-Pays and Limits or exclusions.
 - **Limits or exclusions** - anything the member pays for non-covered services or services that exceed plan limits.

Coverage Examples

About these Coverage Examples:

- ▶ Each issuer must calculate and populate the *Plan pays* amount by subtracting the *Patient pays* total from the *Amount owed to providers* total.
- ▶ If the issuer has a wellness program that varies the deductibles, co-payments, co-insurance, or coverage for any of the services listed in a treatment scenario, the plan must complete the calculations for that treatment scenario assuming that the patient is participating in the wellness program. Additionally, the issuer must also include a box below the coverage example with the following language (and appropriate contact information):
 - For Pregnancy:
 - Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: [insert].
 - For Diabetes:
 - 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].

Coverage Examples

About these Coverage Examples:

- ▶ 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%)” is added after the Patient pays amount. Otherwise no narrative should appear after the Patient pays amount.
- ▶ Issuers must include the Questions and answers about the Coverage Examples section as it appears and not alter the text, font, graphic, shading, etc. This section should be placed immediately following the Coverage Examples.

Helpful links

- ▶ For SBC completion questions, contact SBC@cms.hhs.gov.
- ▶ ACA FAQs – Set 9 – regarding SBCs
 - http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html
- ▶ SBC Coverage Example Calculator Instructions
 - <https://www.cms.gov/CCIIO/Resources/Files/Downloads/sbc-cover-ex-calc-instructions.pdf>
- ▶ Template, Language Versions of Template, Uniform Glossary, Sample Completed SBC, Instructions for Completing the SBC (Group and Individual),
 - <http://www.cms.gov/cciiio/Resources/forms-reports-and-other-resources/index.html>
- ▶ SBC completed sample:
 - <http://www.cms.gov/CCIIO/Resources/Files/Downloads/sbc-sample.pdf>
- ▶ Federal Final Rule CMS–9982–P – 8/22/11:
 - <http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21192.pdf#page=1>
- ▶ Federal Final Rule CMS–9982–F – 2/14/12:
 - <http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf#page=2>

Questions?

Online viewers may e-mail questions now to
insurance.video@state.or.us

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