Understanding the Summary of Benefits and Coverage

This job aid provides information and guidance that Navigators, Certified Application Counselors (CACs), and Enrollment Assistance Personnel (EAPs) (collectively, assisters) need to know in order to interpret the Summary of Benefits and Coverage (SBC) for health plans and assist consumers with using the SBC to compare health plan benefits.

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Version 3.0. April 2024. This information is intended only for the use of entities and individuals certified to serve as Navigators, certified application counselors, or non-Navigator assistance personnel in a Federally-facilitated Marketplace. The terms “Federally-facilitated Marketplace” and “FFM,” as used in this document, include FFMs where the state performs plan management functions. Some information in this manual may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces using the Federal Platform. This material was produced and disseminated at U.S. tax filer expense.

SBC Overview

Section 2715 of the Public Health Service Act (PHS Act)[i], as added by the Affordable Care Act (ACA), generally requires all group health plans and health insurance companies offering group or individual health insurance to provide applicants, enrollees, and policyholders an SBC that accurately describes the benefits and coverage under the plan to help consumers compare the different features of health benefits and coverage. The specified rules governing SBC requirements are described in section 45 CFR 147.200.[ii] The SBC is a consumer shopping tool that provides a snapshot of a health plan's costs, benefits, covered health care services, limitations and exceptions, and other features that may be important to consumers. The SBC also explains health plans' unique features, like cost-sharing rules, and includes descriptions of significant limits and exceptions to coverage in easy-to-understand terms. Review a sample completed SBC.

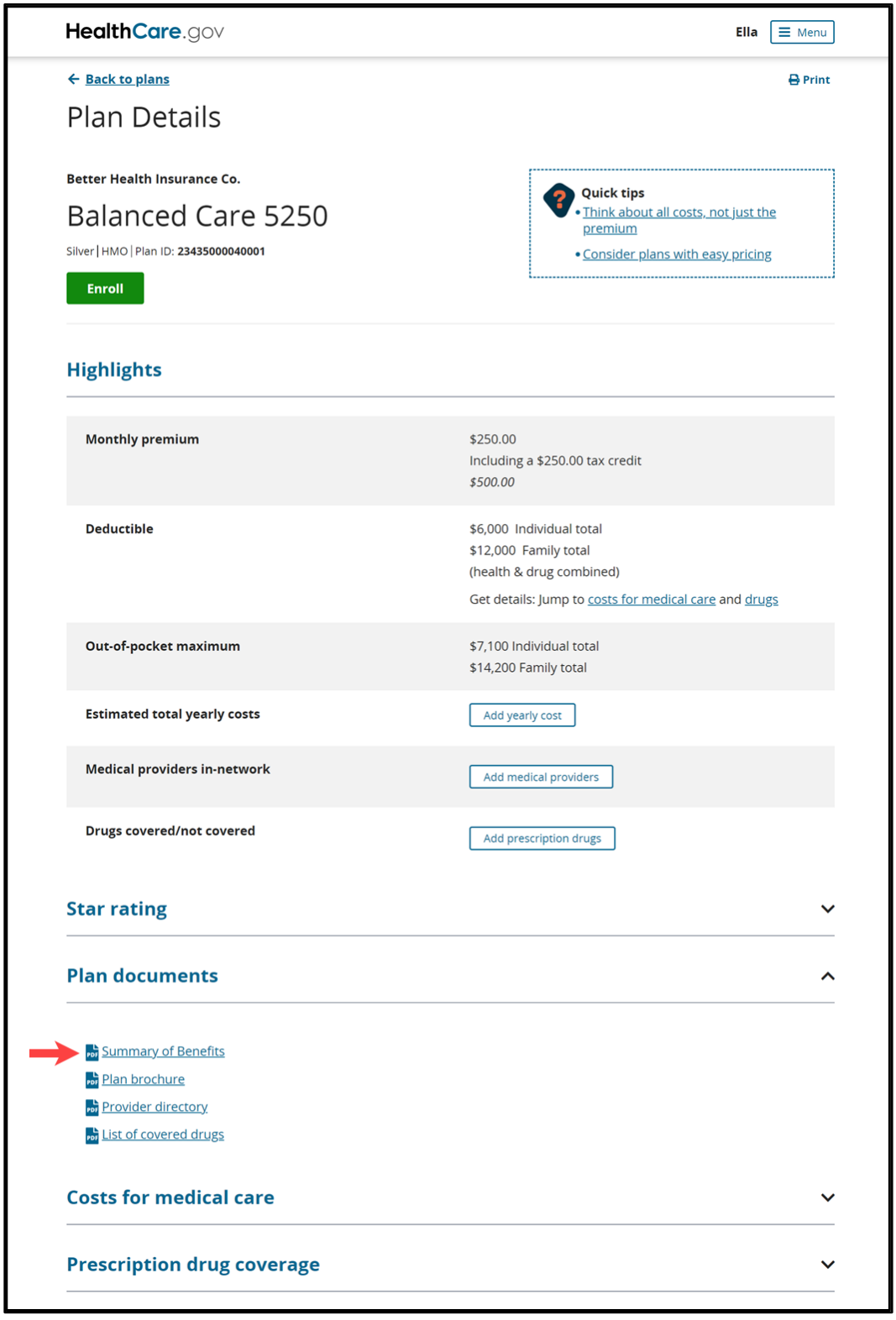
Group health plans and health insurance companies offering group or individual health insurance must also provide a Uniform Glossary to explain common medical and insurance-related terms. Review the Uniform Glossary.

The sample SBC used below is for illustrative purposes only and is not intended to reflect an actual Marketplace plan option. As consumers compare qualified health plans (QHPs) offered through the Marketplaces, you can help them understand some of the benefits offered in each plan by guiding them through the SBC.

Helping Consumers Locate the SBC

Consumers may access the SBC within each health plan's detailed view at HealthCare.gov when they preview plans and prices before logging in as well as when they've completed their application and are comparing plans. The "Plan Details" page allows consumers to learn more about a health plan's benefits before they select and enroll in a plan. Refer to Exhibit 1 for an example of a health plan's detailed view.

Exhibit 1 - HealthCare.gov Screenshot: Plan Details Page



Health plans must also provide the SBC at specific times:

- **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.
- **Upon renewal, reissuance, or reenrollment:**
  - If 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.
- **Upon request:** As soon as 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):** 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.

The consumer may be able to get the SBC and Uniform Glossary in a language other than English upon request. The SBC must include language access taglines that indicate the availability of language services. Consumers can check that section of the SBC to see if they can request an SBC and assistance in their preferred language. It will include a phone number they can call to request the translated version from their insurance company. They can also ask for a copy of the Uniform Glossary to help them understand words used in health coverage and medical care. The Uniform Glossary is also available on the CMS SBC web page in several of the most common languages spoken in the U.S.

Helping Consumers Review the SBC

Assisters should help consumers understand that all SBCs contain the following parts:

- **Important Questions:** Consumers can use this section to understand some of the health plan's costs, including deductible amounts and out-of-pocket limits. This section also contains information on coverage for in-network and out-of-network providers.

- **Common Medical Events:** This section provides cost-sharing information, such as copayments and coinsurance amounts, and significant limitations or exclusions for certain common medical events, including a visit to a provider's office, an MRI or CT scan, a hospital stay, and prescription drug information.

- **Excluded Services and Other Covered Services:** Consumers can use this section to learn about certain services that are not covered by their health plan as well as some additional services the plan does cover.

- **Coverage Examples:** This section shows what the plan would cover in three common medical situations: a simple fracture, diabetes care, and having a baby. These standardized, hypothetical coverage examples help facilitate apples-to-apples comparisons between plans and help consumers get an idea of how much financial protection the plan is generally expected to provide for common health conditions. Consumers should not use these coverage examples to estimate their actual costs under a plan because actual services and costs depend on consumers' individual medical needs when they consult with a provider.

- **Uniform Glossary:** Each SBC contains a link to a glossary with consumer-friendly explanations of common medical and insurance terms such as "deductibles" and "premiums." All health insurance issuers use the same glossary. The Uniform Glossary is available as an interactive web page and in PDF format.

- **Disclosures:** Consumers can use this section to find out about continuing coverage, grievance and appeals rights, if the plan provides minimum essential coverage, if it meets minimum value standards, and available language access services.

  Minimum essential coverage (MEC) generally includes group health plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, and certain other coverage. A consumer may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace if they are eligible for other MEC. This includes if they can enroll in an employer plan that is considered affordable and that provides minimum value or if they do enroll in an employer plan that offers minimum value. A plan offers minimum value if the percentage of the total allowed costs of benefits provided under the plan is at least 60 percent and the benefits under the plan include substantial coverage of inpatient hospital services and physician services.

You should remind consumers that they can use the SBC to answer their general questions about a health plan before selecting and enrolling in a plan. Consumers can contact the insurance company offering a plan for information about how it can help them pay for specific health services, and they should review the insurance policy closely. You should also remind consumers that their benefits and coverage under a health plan may change during the benefit year or when a new benefit year begins, which is very common.

If information on a plan's SBC changes in the middle of a benefit year and that change is one that most consumers would consider important in their decision-making on which plan to choose, the health insurance company offering that plan must notify consumers of any changes at least 60 days before they go into effect. Before a new benefit year begins, consumers should expect a new SBC to be available from their health insurance company that reflects any changes to their plan that will be in effect during the new benefit year.

Scenario: Helping a Consumer Use the SBC to Compare Health Plans

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

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

   Direct Ella to the Important Questions chart on the SBC. The last important question and answer on this chart indicates whether Ella would need a referral before she visits a specialist. A sample Important Questions chart is displayed below in Exhibit 2.

Exhibit 2 – Sample SBC: Important Questions Chart

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

Coverage Period: 1/1/2024 – 12/31/2024
Coverage for: Family | Plan Type: PPO

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

Important Questions	Answers	Why This Matters
What is the overall deductible?	$500 / Individual or $1,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage and $300 for occupational therapy services. 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.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out- of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

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

   First, direct Ella to the Important Questions chart of the SBC shown in Exhibit 2 above. Explain that Ella must meet the deductible amount in the first row before the insurance company would begin to pay for most covered services. In this example, the plan has a $500 per-person or $1,000 per-family overall deductible and a $300 specific deductible for prescription drug coverage, as shown in the third row.

Next, direct Ella to the Common Medical Events chart shown in Exhibit 3 below. This chart shows the potential cost-sharing amounts Ella might be responsible for if she receives various health care services after meeting the plan's deductible(s).

For example:

- If Ella visits an in-network specialist, she would have to pay a $50 copayment per visit, once she has met her deductible.

- If Ella visits an out-of-network specialist, she would have to pay a 40 percent coinsurance, or 40 percent of the allowed amount, per visit, once she has met her deductible. For example, if the plan's allowed amount for an out-of-network specialist visit is $200, her coinsurance payment of 40 percent would be $80. In addition, if the out-of-network specialist's charge is more than the plan's allowed amount, the provider may charge her for the difference between the provider's charge and the plan's allowed amount (sometimes called "balance billing"). For example, if the specialist's charge was $250 in the example above, Ella would have to pay the $80 coinsurance plus the difference between the specialist charge and the allowed amount ($50), for a total cost of $130. This is why it is often beneficial for enrollees to visit in-network providers, where out-of-pocket costs are typically lower.

  Ella can contact the plan's customer service line to find out what the allowed amount would be for the visit. Once she enrolls in a plan, she can also use the consumer's cost estimator tool to find the allowed amount.

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

Note: Beginning January 1, 2022, the No Surprises Act protects consumers from surprise medical bills in situations where they can't easily choose a provider who is in their health plan's network. The No Surprises Act and implementing regulations ban high out-of-network cost sharing for certain emergency and non-emergency services. Patient cost sharing, such as coinsurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network provider rates. For more information, visit the CMS No Surprises Act website and the CMS Medical Bill Rights website, and review The No Surprises Act: An Overview for Assisters, Advocates, Agents, and Brokers.

Exhibit 3 – Sample SBC: Common Medical Events Chart

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

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

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

Exhibit 4 – Sample SBC: Contact Information

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

Coverage Period: 1/1/2024 – 12/31/2024
Coverage for: Family | Plan Type: PPO

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

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

   To answer this question, direct Ella to return to page 1 of the SBC (shown in Exhibit 2) and find the row labeled "What is the out-of-pocket limit for this plan?" The out-of-pocket limit, as explained in the Uniform Glossary, is the most Ella could pay in cost sharing during a policy period (for individual market coverage, this is usually one calendar year or part of a calendar year ending December 31) before her health insurance company begins to pay 100 percent of the allowed amount for covered services. In this example, if Ella spends over $2,500 for services from in-network providers, the health insurance company will begin to pay 100 percent of the allowed amount for covered services. The out-of-pocket limit never includes premiums, balance-billed charges, or health care the health insurance company doesn't cover. Additionally, some health insurance companies don't count all copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

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

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

Additional Resources

For more information, visit:

- **CMS.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:**
  - Summary of Benefits and Coverage Overview Webinar
  - The Health Insurance Marketplace: Know Your Rights

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[i] Housedocs.house.gov/energycommerce/phsa027.pdf
[ii] Ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-147/section-147.200