

that is consistent with the rules of paragraph (a)(4) of this section.

(c) *Uniform glossary*—(1) *In general.* A group health plan, and a health insurance issuer offering group health insurance coverage, must make available to participants and beneficiaries, and a health insurance issuer offering individual health insurance coverage must make available to applicants, policyholders, and covered dependents, the uniform glossary described in paragraph (c)(2) of this section in accordance with the appearance and format requirements of paragraphs (c)(3) and (c)(4) of this section.

(2) *Health-coverage-related terms and medical terms.* The uniform glossary must provide uniform definitions, specified by the Secretary in guidance, for the following health-coverage-related terms and medical terms:

(i) Allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network co-insurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and

(ii) Such other terms as the Secretary determines are important to define so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits), as specified in guidance.

(3) *Appearance.* A group health plan, and a health insurance issuer, must provide the uniform glossary with the appearance authorized in guidance, ensuring that the uniform glossary is presented in a uniform format and utilizes terminology understandable by the average plan enrollee (or, in the case of individual market coverage, an average individual covered under a health insurance policy).

(4) *Form and manner.* A plan or issuer must make the uniform glossary described in this paragraph (c) available upon request, in either paper or

electronic form (as requested), within seven days of the request. (Under the rules of paragraph (a) of this section, the form authorized in guidance for the SBC will disclose to participants, beneficiaries, and individuals covered under an individual policy their rights to request a copy of the uniform glossary.)

(d) *Preemption.* For purposes of this section, the provisions of section 2724 of the PHS Act continue to apply with respect to preemption of State law. In addition, with respect to the standards for providing an SBC required under paragraph (a) of this section, State laws that require a health insurance issuer to provide an SBC that supplies less information than required under paragraph (a) of this section are preempted.

(e) *Failure to provide.* A health insurance issuer or a non-Federal governmental health plan that willfully fails to provide information required under this section is subject to a fine of not more than \$1,000 for each such failure. A failure with respect to each covered individual constitutes a separate offense for purposes of this paragraph (e). HHS will enforce these provisions in a manner consistent with 45 CFR 150.101 through 150.465.

(f) *Applicability date.* This section is applicable beginning March 23, 2012. See § 147.140(d) of this chapter, providing that this section applies to grandfathered health plans.

[FR Doc. 2011–21193 Filed 8–17–11; 11:15 am]

BILLING CODE 4120–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[CMS–9982–NC]

45 CFR Part 147

Summary of Benefits and Coverage and Uniform Glossary—Templates, Instructions, and Related Materials Under the Public Health Service Act

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration,

Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Solicitation of comments.

SUMMARY: The Departments of the Health and Human Services, Labor, and the Treasury (the Departments) are simultaneously publishing in the **Federal Register** this document and proposed regulations (2011 proposed regulations) under the Patient Protection and Affordable Care Act to implement the disclosure for group health plans and health insurance issuers of the summary of benefits and coverage (SBC) and the uniform glossary. This document proposes a template for an SBC; instructions, sample language, and a guide for coverage examples calculations to be used in completing the template; and a uniform glossary that would satisfy the disclosure requirements under section 2715 of the Public Health Service (PHS) Act. Comments are invited on these materials.

DATES: *Comment Dates:* Comments are due on or before October 21, 2011.

ADDRESSES: Written comments may be submitted to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments. Please do not submit duplicates.

All comments will be made available to the public. **Warning:** Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Department of Labor. Comments to the Department of Labor, identified by RIN 1210–AB52, by one of the following methods:

- *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.

- *E-mail:* E–OHPSA2715.EBSA@dol.gov.

- *Mail or Hand Delivery:* Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N–5653, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, **Attention:** RIN 1210–AB52.

Comments received by the Department of Labor will be posted

without change to <http://www.regulations.gov> and <http://www.dol.gov/ebsa>, and available for public inspection at the Public Disclosure Room, N-1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW., Washington, DC 20210.

Department of Health and Human Services. In commenting, please refer to file code CMS-9982-NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the instructions under the “More Search Options” tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9982-NC, P.O. Box 8016, Baltimore, MD 21244-1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9982-NC, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document’s paperwork requirements by following the instructions at the end of the “Collection of Information Requirements” section in this document.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1-800-743-3951.

Internal Revenue Service. Comments to the IRS, identified by REG-140038-10, by one of the following methods:

- *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.

- *Mail:* CC:PA:LPD:PR (REG-140038-10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.

- *Hand or courier delivery:* Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG-140038-10), Courier’s Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington DC 20224.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW., Washington, DC from 9 a.m. to 4 p.m.

FOR FURTHER INFORMATION CONTACT:

Amy Turner or Heather Raeburn, Employee Benefits Security

Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622-6080; Jennifer Libster or Padma Shah, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (301) 492-4252.

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor’s Web site (<http://www.dol.gov/ebsa>). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) Web site (http://www.cms.hhs.gov/HealthInsReformforConsumer/01_Overview.asp) and information on health reform can be found at <http://www.healthcare.gov>.

SUPPLEMENTARY INFORMATION:

I. Introduction

The Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments) are taking a phased approach to issuing regulations and guidance implementing the revised Public Health Service Act (PHS Act) sections 2701 through 2719A and related provisions of the Patient Protection and Affordable Care Act (Affordable Care Act).¹ Section 2715 of the PHS Act directs the Departments to develop standards for use by a group health plan and a health insurance issuer in compiling and providing a summary of benefits and coverage (SBC) that “accurately describes the benefits and coverage under the applicable plan or coverage.” Section 2715 of the PHS Act also directs the Departments to provide for the development of a uniform glossary. The statute directs the Departments, in developing such standards, to “consult with the National Association of Insurance Commissioners” (referred to in this document as the “NAIC”), “a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing

¹ The Affordable Care Act also adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans.

individuals with limited English proficiency, and other qualified individuals.”

As part of this required consultation, the NAIC convened the Consumer Information (B) Subgroup (NAIC working group), comprised of a diverse group of stakeholders.² This working group met frequently each month for over one year while developing its recommendations. The NAIC working group created two subgroups—one focused on developing a uniform glossary of health insurance and medical terms and the other focused on developing standards for the SBC. All drafts were discussed and agreed to by the entire NAIC working group and then submitted to the full NAIC membership for a vote to submit the drafts as recommendations to the Departments. Throughout the process, NAIC working group draft documents and meeting notes were displayed on the NAIC’s Web site for public review, and several interested parties filed formal comments. In addition to participation from the NAIC working group members, conference calls and in-person meetings were open to other interested parties and individuals and provided an opportunity for non-member feedback. The NAIC indicates that stakeholders from a diverse pool of backgrounds participated in working group conference calls.³

As a result of this process, the NAIC working group recommended use of a uniform SBC template, as well as a uniform glossary, for the individual and group insurance markets. In developing these recommendations, the draft SBC template, including the coverage examples, and the draft uniform glossary underwent consumer testing,⁴ sponsored by both consumer and insurance industry groups. These tests were intended to assist in determining necessary adjustments to ensure the final product was consumer friendly.⁵

² A list of the NAIC working group members can be found at: http://www.naic.org/documents/committees_b_consumer_information_contacts.pdf.

³ Records and other information relating to all of the meetings held by the NAIC working group can be found at: http://www.naic.org/committees_b_consumer_information.htm.

⁴ The NAIC consulted readability experts and conducted consumer testing. The SBC format was designed to enhance to consumer understanding and usability. For example, use of vocabulary, such as “don’t” versus “do not” reflects intentional design based on feedback from consumer testing. These format choices reflect in part, the NAIC’s efforts to address the statutory requirement that the form be “culturally and linguistically appropriate.”

⁵ Summaries of this consumer testing are available at: http://www.naic.org/documents/committees_b_consumer_information_101012_ahip_focus_group_summary.pdf; http://www.naic.org/documents/committees_b_consumer_

The Departments have received transmittals from the NAIC that include a recommended template for the SBC (referred to in this document as the “SBC template”)⁶ with instructions, samples, and a guide for coverage examples calculations to be used in completing the SBC template. The NAIC transmittals also included a recommended uniform glossary of coverage and medical terms (referred to in this document as the “uniform glossary”). The SBC template and uniform glossary include modifications made by the NAIC working group in response to the results of extensive consumer testing.

The 2011 proposed regulations and this document follow the recommendations made by the NAIC and incorporate the documents drafted by the NAIC, including the SBC template (with instructions, sample language, and a guide for coverage examples calculations to be used in completing the SBC template) and the uniform glossary. The Appendices do not include a sample coverage example calculation for breast cancer in the individual market that was transmitted by the NAIC. Upon review, it appeared that some of the data in the example might be subject to copyright protection. Moreover, the sample coverage example calculation provided by the NAIC was limited to breast cancer in the individual market and did not address the other two coverage examples—maternity coverage and diabetes. Finally, particular coding information and pricing information included in the sample would change annually, which would result in the data included in the sample becoming outdated relatively quickly. Accordingly, HHS is publishing on its Web site (at <http://ccio.cms.gov>) the coding and pricing information necessary to perform coverage example calculations for all three coverage examples. HHS will update this information annually.

Instead of proposing possible changes to the NAIC’s proposed SBC template and related materials at this time, this document proposes to incorporate the

information 110603 ahip bcbsa consumer testing.pdf; http://www.naic.org/documents/committees_b_consumer_information_101014_consumers_union.pdf (a more detailed summary of which is accessible at: http://prescriptionforchange.org/pdf/CU_Consumer_Testing_Report_Dec_2010.pdf); and http://www.naic.org/documents/committees_b_consumer_information_110603_consumers_union_testing.pdf.

⁶ In their materials, the NAIC uses the phrase “Summary of Coverage” to describe the SBC template. However, the Departments use the term “Summary of Benefits and Coverage” in the proposed regulations and this document. Both of these terms are meant to refer to the same document (located in Appendix A–1 of this document).

NAIC working group’s recommended materials as transmitted (with the exception of the sample coverage example, explained above), and invites public comment. The Departments recognize that changes to the SBC template may be appropriate to accommodate various types of plan and coverage designs, to provide additional information to individuals, or to improve the efficacy of the disclosures recommended by the NAIC. In addition, the SBC template and related documents were drafted by the NAIC primarily for use by health insurance issuers.⁷ The NAIC states in its transmittal letter that additional modifications may be needed for some group health plans. Consequently, comments are requested on these issues specifically and on the SBC template, sample completed SBC, instructions for both group health plan coverage and individual health insurance coverage, sample language for the “Why this Matters” section of the SBC, guide for coverage examples calculations, and on the uniform glossary generally. After the public comment period, the Departments will finalize these documents. Consistent with PHS Act section 2715(c), the Departments will periodically review and update these documents as appropriate, taking into account public comments.

II. Proposal

This document proposes an SBC template (with instructions, samples, and a guide for coverage examples calculations to be used in completing the SBC template), and the uniform glossary, to comply with the disclosure requirements of PHS Act section 2715, as authorized by the Departments pursuant to paragraph (a)(4) of the 2011 proposed regulations. The SBC template, sample completed SBC, instructions for both group health plan coverage and individual health insurance coverage, sample language for the “Why This Matters” section of the SBC, guide for coverage examples calculations, and uniform glossary are identical to the documents transmitted by the NAIC. These items are contained in the Appendices to this document.

In addition to the materials in the Appendices that are proposed in this document, HHS is providing (at <http://ccio.cms.gov>) the specific information necessary to simulate benefits covered under the plan or policy for the

⁷ National Association of Insurance Commissioners, Consumer Information Working Group, December 17, 2010 Letter to the Secretaries. Available at http://www.naic.org/documents/committees_b_consumer_information_ppaca_letter_to_sebelius.pdf.

coverage examples portion of the SBC (including specific medical items and services, dates of service, billing codes, and allowed charges for each claim in the three specified benefits scenarios). HHS will update this information annually on its Web site. The Departments propose that plans and issuers are not required to update their coverage examples for SBCs provided before the date that is 90 days after the date that HHS provides this updated information. That is, 90 days after HHS updates the information, SBCs that are otherwise required to be provided under paragraph (a) of the proposed rules should take into account the new information when providing coverage examples. For example, if HHS releases updated information on September 15 of a year, SBCs required to be provided on or after December 14 of that year under the rules of paragraph (a) of the proposed rules would need to include coverage examples calculated using the new information. However, these updates alone will not be considered a material modification under paragraph (b) of the 2011 proposed regulations. Comments are invited on this information as well, including the annual update provision. The preamble to the 2011 proposed regulations contains a request for comment regarding various approaches to providing the coverage examples. Commenters addressing the requirement to provide updated coverage examples are encouraged to consider how updates would be made to the coverage examples under these various approaches and what additional instructions should be added to address updates and a possible phased-in approach to implementation discussed in the preamble to the 2011 proposed regulations.

With respect to the element of the SBC regarding a statement about whether a plan or coverage provides minimum essential coverage (as defined under section 5000A(f) of the Code) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable minimum value requirements (minimum essential coverage statement),⁸ because this content is not relevant until other elements of the Affordable Care Act are implemented, this statement is not in

the NAIC recommendations. For the same reason, and as discussed more fully in the preamble to the 2011 proposed regulations, the minimum essential coverage statement is not required to be in the SBC until the plan or coverage is required to provide an SBC with respect to coverage beginning on or after January 1, 2014. As provided in the preamble to the 2011 proposed regulations, comments are requested on how employers might provide the information included in the minimum essential coverage statement and other plan-level reporting in a manner that minimizes duplication and burden.

In addition, the SBC template recommended by the NAIC and located in Appendix A–1 of this document includes Web sites for individuals to access the uniform glossary, for information about prescription drug coverage, and for information about the plan or coverage provider network. The Departments note, however, these Web sites are not working Web sites. Plans and issuers would need to modify this aspect of the SBC template to include relevant, working Web addresses (for the uniform glossary, this may be the Web address of either the Department of Labor or HHS Web site, or on the plan's or issuer's own Web site). The Departments invite comment on whether this statement in the SBC template regarding the electronically available uniform glossary should be modified to include a statement that the uniform glossary is available in paper form upon request.

III. Solicitation of Comments

The Departments solicit comments generally on the SBC template and related documents and the uniform glossary included in the Appendices, as well as on specific issues set forth below (including on what modifications, if any, are needed for group health plans to use the SBC template).

The NAIC stated in the December 2010 transmittal letter that the working group intentionally designed the layout and color of the SBC template based on consumer testing to make the document more readable and to facilitate comparison of different plan and coverage options. The Departments recognize, however, that color printing may be costly for some plans and issuers and therefore propose that a plan or issuer will be compliant if it uses either the color version (available on the Web sites of the Departments of Labor and HHS),⁹ as recommended by the NAIC, or the grayscale version (included

in the Appendices to this document). In addition, the Departments note that while the NAIC-recommended SBC template is only three double-sided pages, the Departments are proposing that a completed SBC may be four double-sided pages in length. The SBC template reserves space to ensure that a plan or issuer with different benefit designs (such as multiple, tiered provider networks) could provide all the necessary information, and that additional coverage examples could be added in the future, within four double-sided pages. (See the preamble to the 2011 proposed regulations for a request for comment regarding various approaches to providing the coverage examples.)

The Departments are interested in any general comments regarding the proposed SBC template, sample completed SBC, instructions for both group health plan coverage and individual health insurance coverage, sample language for the “Why This Matters” section of the SBC, guide for coverage examples calculations, and uniform glossary. In making this request for comment, the Departments note that the purpose of PHS Act section 2715 is to provide individuals and plan participants with a brief summary of plan or policy benefits and coverage so that they may more easily compare health care coverage and better understand the terms of coverage (or exceptions to the coverage). The SBC is intended to assist individuals purchasing coverage in the individual market in comparing the benefits and coverage of different individual policies offered by insurance issuers. Likewise, the SBC is intended to assist employees who are offered group coverage to compare among different employer-provided health care options or to compare their employer's options with other coverage for which they may be eligible, such as a spouse's or dependent's offer of employer-provided health care coverage, a former employer's COBRA continuation coverage,¹⁰ or a policy on the individual market.

In order to make it as easy as possible for individuals to understand the terms of their own coverage and compare coverage and benefits efficiently and accurately, the statute provides for, and the NAIC recognized the importance of, presenting the SBC in a uniform format. We invite comments on how this statutory requirement should be

⁸ PHS Act section 2715(b)(3)(C) provides that this statement must indicate whether the plan or coverage (1) provides minimum essential coverage (as defined under section 5000A(f) of the Code) and (2) ensures that the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs.

⁹ See <http://www.dol.gov/ebsa> or <http://cciio.cms.gov>.

¹⁰ As defined in 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103, COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

applied, including the nature and extent of the uniformity that should be required in the specific language of the SBC and the manner and sequence in which the information in the SBC is presented. We ask that any comments proposing that flexibility be permitted in aspects of the presentation of the SBC explicitly address the potential positive or negative effects on individuals' ability to effectively compare benefits and coverage among and across individual policies and group health plans.

The Departments also invite comments on the following specific issues:

1. The SBC template is intended to be used by all types of plan or coverage designs. The Departments are interested in comments related to issues that may arise from the use of this template for different types of plan or coverage designs (for example, designs using tiered provider networks or group health plans that may use multiple issuers or service providers to provide or administer different categories of benefits within a benefit package).

2. The Departments are interested in comments regarding any modifications needed for use by group health plans (e.g., with respect to disclosure regarding cost of coverage and changes in terminology required for self-insured plans, such as use of the term "plan year" instead of "policy period").

3. The Departments are interested in comments regarding whether the content of the SBC should require inclusion of additional information, such as information regarding any preexisting condition exclusion under the plan or policy,¹¹ status as a grandfathered health plan,¹² or other information that might be important for individuals to know about their coverage and how the SBC template could be modified to ensure effective disclosure of these additional elements, while respecting the statutory formatting requirements. For example, comments are requested on whether a

simplified reporting method, such as a checkbox, could be used to disclose preexisting condition exclusions and grandfather status.

4. The fourth page of the SBC template includes a list of services that plans and issuers must indicate as either excluded or covered in the "Excluded Services & Other Covered Services" chart. The Departments solicit comments on whether services should be added or removed from this list, as well as whether the disclosure stating that the list is not complete is adequate.

5. The SBC template includes a disclosure on the first page indicating to consumers that the SBC is not the actual policy and does not include all of the coverage details found in the actual policy. The Departments solicit comments on whether this disclosure is adequate.

The uniform glossary is also included in Appendix E of this document. The Departments propose that plans and issuers cannot make any modifications to this glossary. The uniform glossary was developed to facilitate and enhance consumer comprehension and is not intended to provide legal or contractual definitions that necessarily apply accurately, without modification, to every plan or coverage. The NAIC consumer testing found that certain terms relating to cost-sharing provisions were particularly difficult for consumers to understand. As a result, the NAIC developed diagrams to accompany the textual definitions of these terms. The Departments solicit comments on the uniform glossary, including its terms and definitions, and whether other terms should be added to the glossary, as well as whether any of the terms would be considered inaccurate or misleading based on a particular plan or coverage design.

Comments are also invited on the standards set forth in the 2011 proposed regulations. To comment on the 2011 proposed regulations, see the comment section of the 2011 proposed regulations, published elsewhere in this issue of the **Federal Register**.

IV. Paperwork Reduction Act

According to the Paperwork Reduction Act of 1995 (Pub. L. 104–13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information

unless it displays a currently valid OMB control number. *See* 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. *See* 44 U.S.C. 3512.

This document relates to the information collection request (ICR) contained in a proposed regulation titled "Summary of Benefits and Coverage and the Uniform Glossary," which is published elsewhere in today's issue of the **Federal Register**. For a discussion of the hour and cost burden associated with the ICR, please see the notice of proposed rulemaking.

Sarah Hall Ingram,

Acting Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Signed this 15th day of August, 2011.

Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: July 28, 2011.

Donald Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Dated: August 9, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

V. Appendices

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Overview of Appendices

As stated earlier in this document, the NAIC transmitted the work of the NAIC Working Group to the Departments. The Appendices to this document include the SBC documents drafted by the NAIC in their entirety, with the exception of the sample coverage example calculation for breast cancer in the

¹¹ **Note:** The general notice of preexisting condition exclusion and the individual notice of preexisting condition exclusion at 26 CFR 54.9801–3(c) and (e), 29 CFR 2590.701–3(c) and (e), and 45 CFR 146.111(c) and (e), were published as part of the Departments' HIPAA portability regulations on December 30, 2004, 69 FR 78720.

¹² **Note:** Under paragraph (a)(2) of the Departments' interim final regulations regarding status as a grandfathered health plan, to maintain grandfather status, group health plans and health insurance coverage must include a statement in any plan materials describing the benefits provided that the plan or coverage believes it is a grandfathered health plan. Model language is provided. *See* 26 CFR 54.9815–1251T(a)(2), 29 CFR 2590.715–1251(a)(2), and 45 CFR 147.140(a)(2), published in the **Federal Register** on June 17, 2010, 75 FR 34538.

individual market, as explained earlier in this document.

Appendix A-1 contains an SBC template, as developed by the NAIC Working Group. The NAIC Working Group incorporated all of their recommendations contained in the multiple transmittals to the Departments over the last several months in their final recommended SBC template.

Appendix A-2 contains a sample completed SBC, using information for a sample individual health insurance policy. While the sample completed SBC may not align perfectly with the instructions in every way, the document is useful in providing a general illustration of a completed SBC for a sample insurance policy.

Appendices B-1 and B-2 contain instructions for group health coverage and individual health insurance coverage, respectively, to use in completing the SBC template. The Departments are publishing the sample

completed SBC and the instructions to facilitate compliance with the requirements of the 2011 proposed regulations and this document.

The SBC instructions include language that must be used when completing the “Why This Matters” column on the first page of the SBC template. Depending on the design of the policy or plan, there are two language options provided in Appendices C-1 (for when the answer in the applicable row is “yes”) and C-2 (for when the answer in the applicable row is “no”). Appendices C-1 and C-2 provide an example of how this column will look when populated with the required language, as applicable depending upon the terms of the plan or coverage.

Appendix D contains a guide for use by a plan or issuer in compiling information related to the coverage examples. This document, together with information provided in Microsoft Excel

format by HHS at <http://cciio.cms.gov>, comprises all the information necessary to perform coverage example calculations for all three coverage examples. HHS will update the information on its Web site annually. With respect to these annual updates, the Departments propose that 90 days after HHS updates the information, SBCs that are otherwise required to be provided under paragraph (a) of the 2011 proposed rules would take into account the new information when providing coverage examples.

Finally, Appendix E contains the Uniform Glossary of Health Insurance and Medical Terms.

The Departments invite comments on all of the documents in the Appendices to this document and their use in relation to the requirements of the 2011 proposed regulations and this document.

BILLING CODE 4120-01-P

Appendix A-1 Summary of Benefits and Coverage (SBC) Template

Summary of Coverage: What this Plan Covers & What it Costs Policy Period: _____ Coverage for: _____ Plan Type: _____

! This is not a policy. You can get the policy at www.insurancecompany.com/PLAN1500 or by calling 1-800-XXX-XXXX. A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions		Answers	Why this Matters:
What is the premium?	\$		The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible?	\$		
Are there other deductibles for specific services?	\$		
Is there an out-of-pocket limit on my expenses?	\$		
What is not included in the out-of-pocket limit?			
Is there an overall annual limit on what the insurer pays?			
Does this plan use a network of providers?			
Do I need a referral to see a specialist?			
Are there services this plan doesn't cover?			

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com. If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

OMB Control Numbers 1545-XXXX,
1210-XXXX, and 0938-XXXX
(expires XX/XX/XXXX)

Summary of Coverage: What this Plan Covers & What It Costs Policy Period: _____ Coverage for: _____ Plan Type: _____



- Co-payments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your co-insurance payment of 20% would be \$200. If you haven't met any of the deductible and it's at least \$1,000, you would pay the full cost of the hospital stay.
- The plan's payment 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, co-payments and co-insurance amounts.

Common Medical Event	Your cost if you use a			Limitations & Exceptions
	Services You May Need	Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness			
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
	Generic drugs			
	Preferred brand drugs			
If you need drugs to treat your illness or condition	Non-preferred brand drugs			
	Specialty drugs (e.g., chemotherapy)			
	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
More information about drug coverage is at www.insurance.com/insurancesummary	Emergency room services			

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insurance.com/terms.

Summary of Coverage: What this Plan Covers & What it Costs Policy Period: Coverage for: Plan Type:

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Participating Provider	Non-Participating Provider		
Immediate medical attention	Emergency medical transportation				
	Urgent care				
	Facility fee (e.g., hospital room)				
If you have a hospital stay	Physician/surgeon fee				
	Mental/Behavioral health outpatient services				
	Mental/Behavioral health inpatient services				
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder outpatient services				
	Substance use disorder inpatient services				
	Prenatal and postnatal care				
If you become pregnant	Delivery and all inpatient services				
	Home health care				
	Rehabilitation services				
If you have a recovery or other special health need	Habilitation services				
	Skilled nursing care				
	Durable medical equipment				
If your child needs dental or eye care	Hospital service				
	Eye exam				
	Glasses				
	Dental check-up				

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)
• • • • •

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Summary of Coverage: What this Plan Covers & What it Costs	Policy Period: _____	Coverage for: _____ Plan Type: _____
Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)		
.		

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

Your Grievance and Appeals Rights:

- A grievance is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit www.XXXXXXXXXX.com.
- An appeal is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at 1-800-XXX-XXXX or visit www.XXXXXXXXXX.gov.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Coverage Examples

Policy Period: _____
Coverage for: _____ Plan Type: _____

About these Coverage Examples:

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much insurance protection you might get from different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$10,000
 ■ Plan pays \$
 ■ You pay \$

Sample care costs:

First office visit	\$100
Radiology	\$300
Laboratory tests	\$200
Routine obstetric care	\$2,000
Hospital charges (mother)	\$4,100
Hospital charges (baby)	\$1,900
Anesthesia	\$1,000
Circumcision	\$200
Vaccines, other preventive	\$200
Total	\$10,000

You pay:

Deductibles	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$

Treating breast cancer (surgery, chemotherapy, radiation)

- Amount owed to providers: \$98,000
 ■ Plan pays \$
 ■ You pay \$

Sample care costs:

Office visits & procedures	\$4,000
Radiology	\$4,000
Laboratory tests	\$2,400
Hospital charges	\$3,300
Inpatient medical care	\$200
Outpatient surgery	\$3,400
Chemotherapy	\$64,000
Radiation therapy	\$13,000
Prostheses (wig)	\$500
Pharmacy	\$2,000
Mental health	\$1,200
Total	\$98,000

You pay:

Deductibles	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$

Managing diabetes (routine maintenance of existing condition)

- Amount owed to providers: \$7,800
 ■ Plan pays \$
 ■ You pay \$

Sample care costs:

Office visits & procedures	\$960
Laboratory tests	\$300
Medical equipment & supplies	\$40
Pharmacy	\$6,500
Total	\$7,800

You pay:

Deductibles	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Coverage Examples _____ Policy Period: _____ Plan Type: _____
 Coverage for: _____

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

*** No.** Treatments shown are just examples. The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

*** No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com. If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Appendix A-2 Sample Completed SBC (Individual Health Insurance Coverage)

Insurance Company 1: PPO Plan 1

Policy Period: 1/1/2011 – 12/31/2011
Coverage for: Individual + Spouse | Plan Type: PPO

Summary of Coverage: What this Plan Covers & What it Costs



This is not a policy. You can get the policy at www.insurancecompany.com/PLAN1900 or by calling 1-800-XXXX-XXXX. A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions		Answers	Why this Matters:
What is the premium?	\$481 monthly		The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible?	\$2,500 person / \$7,500 family Doesn't apply to preventive care		You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy 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 pharmacy expenses		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, \$2,500 person / \$7,500 family		The out-of-pocket limit is the most you could pay during a policy period 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?	Co-payments, premium, balance-billed charges, prescription drugs, and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out-of-pocket limit. So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the insurer pays?	No.		The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.insurancecompany.com for a list of participating doctors and hospitals.		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. Plans use the term in-network, preferred, or participating for providers in their network.
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 in the "Excluded Services & Other Covered Services" section.

Questions: Call 1-800-XXXX-XXXX or visit us at www.insurancecompany.com.If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

OMB Control Numbers 1545-XXXX,

1210-XXXX, and 0938-XXXX

(expires XX/XX/XXXX)

Insurance Company 1: PPO Plan 1

Summary of Coverage: What this Plan Covers & What It Costs

Policy Period: 1/1/2011 – 12/31/2011
Coverage for: Individual + Spouse | Plan Type: PPO



- Co-payments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your co-insurance payment of 20% would be \$200. If you haven't met any of the deductible and it's at least \$1,000, you would pay the full cost of the hospital stay.
- The plan's payment 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 participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Participating Provider	Non-Participating Provider	Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 co-pay/visit		40% co-insurance	none
	Specialist visit	\$50 co-pay/visit		40% co-insurance	none
	Other practitioner office visit	20% co-insurance for chiropractor and acupuncture		40% co-insurance for chiropractor and acupuncture	none
If you have a test	Preventive care/screening/immunization	\$0		40% co-insurance	
	Diagnostic test (x-ray, blood work)	0% co-insurance		40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	0% co-insurance		40% co-insurance	none
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions	Generic drugs	\$10 co-pay (retail), \$10 co-pay (mail order)		40% co-insurance	Covers up to a 30-day supply (retail prescription), 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% co-insurance (retail and mail order)		40% co-insurance	none
	Non-preferred brand drugs	40% co-insurance (retail and mail order)		60% co-insurance	none
	Specialty drugs (e.g., chemotherapy)	0% co-insurance			none

Questions? Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Insurance Company 1: PPO Plan 1

Summary of Coverage: What this Plan Covers & What it Costs **Policy Period: 1/1/2011 – 12/31/2011**
Coverage for: Individual + Spouse | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-insurance	40% co-insurance	none
	Physician/surgeon fees	0% co-insurance	40% co-insurance	none
If you need immediate medical attention	Emergency room services	0% co-insurance	40% co-insurance	none
	Emergency medical transportation	0% co-insurance	40% co-insurance	none
If you have a hospital stay	Urgent care	0% co-insurance	40% co-insurance	none
	Facility fee (e.g., hospital room)	0% co-insurance	40% co-insurance	none
If you have mental health, behavioral health, or substance abuse needs	Physician/surgeon fee	0% co-insurance	40% co-insurance	none
	Mental/Behavioral health outpatient services	0% co-insurance	40% co-insurance	After 8 visits, not covered.
If you become pregnant	Mental/Behavioral health inpatient services	0% co-insurance	40% co-insurance	none
	Substance use disorder outpatient services	0% co-insurance	40% co-insurance	none
If you have a recovery or other special health need	Substance use disorder inpatient services	0% co-insurance	40% co-insurance	none
	Prenatal and postnatal care	Not Covered	Not Covered	none
If your child needs dental or eye care	Delivery and all inpatient services	Not Covered	Not Covered	none
	Home health care	Not Covered	Not Covered	none
	Rehabilitation services	0% co-insurance	40% co-insurance	none
	Habilitation services	0% co-insurance	40% co-insurance	none
	Skilled nursing care	0% co-insurance	40% co-insurance	none
	Durable medical equipment	0% co-insurance	40% co-insurance	none
	Hospital service	0% co-insurance	40% co-insurance	none
	Eye exam	Not Covered	Not Covered	none
	Glasses	Not Covered	Not Covered	none
	Dental check-up	Not Covered	Not Covered	none

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Insurance Company 1: PPO Plan 1

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011
Coverage for: Individual + Spouse | Plan Type: PPO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)	
• Bariatric surgery	• Dental care (Adult)
• Non-emergency care when traveling outside the U.S.	• Infertility treatment
• Cosmetic surgery	• Long-term care
	• Private-duty nursing
	• Routine eye care (Adult)
	• Routine foot care
	• Routine hearing tests
	• Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)	
• Acupuncture	
• Chiropractic care	
• Hearing aids	

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

Your Grievance and Appeals Rights:

- A grievance is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit www.XXXXXXXX.com.
- An appeal is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at 1-800-XXX-XXXX or visit www.XXXXXXXX.gov.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Insurance Company 1: PPO Plan 1 Coverage Examples

Policy Period: 1/1/2011 – 12/31/2011
Coverage for: Individual + Spouse | Plan Type: PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much insurance protection you might get from different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$10,000
- Plan pays \$0
- You pay \$10,000 (maternity is not covered, so you pay 100%)

Sample care costs:

First office visit	\$100
Radiology	\$300
Laboratory tests	\$200
Routine obstetric care	\$2,000
Hospital charges (mother)	\$4,100
Hospital charges (baby)	\$1,900
Anesthesia	\$1,000
Circumcision	\$200
Vaccines, other preventive	\$200
Total	\$10,000

You pay:

Deductibles	\$0
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$10,000
Total	\$10,000

Treating breast cancer (surgery, chemotherapy, radiation)

- Amount owed to providers: \$98,000
- Plan pays \$94,800
- You pay \$3,200

Sample care costs:

Office visits & procedures	\$4,000
Radiology	\$4,000
Laboratory tests	\$2,400
Hospital charges	\$3,300
Inpatient medical care	\$200
Outpatient surgery	\$3,400
Chemotherapy	\$64,000
Radiation therapy	\$13,000
Prostheses (wig)	\$500
Pharmacy	\$2,000
Mental health	\$1,200
Total	\$98,000

You pay:

Deductibles	\$2,500
Co-pays	\$200
Co-insurance	\$0
Limits or exclusions	\$500
Total	\$3,200

Managing diabetes (routine maintenance of existing condition)

- Amount owed to providers: \$7,800
- Plan pays \$6,800
- You pay \$1,000

Sample care costs:

Office visits & procedures	\$960
Laboratory tests	\$300
Medical equipment & supplies	\$40
Pharmacy	\$6,500
Total	\$7,800

You pay:

Deductibles	\$300
Co-pays	\$260
Co-insurance	\$400
Limits or exclusions	\$40
Total	\$1,000

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com. If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Insurance Company 1: PPO Plan 1 Coverage Examples

Policy Period: 1/1/2011 – 12/31/2011
Coverage for: Individual + Spouse | Plan Type: PPO

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

*** No.** Treatments shown are just examples. The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

*** No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com. If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Appendix B-1

Instructions– Group Health Plan Coverage

What Your Plan Covers and What it Costs**Draft Instruction Guide for Group Policies**

Edition Date: July 2011

Purpose of the form: Beginning in March 2012, the Patient Protection and Affordable Care Act (PPACA) requires all health insurance issuers offering group health insurance coverage to provide enrollees and potential enrollees an accurate summary of benefits and coverage explanation. This form does not apply to excepted benefits as defined by the Public Health Services Act (PHSA). Federal law requires this document so eligible employees will find it easier to compare policies and understand their coverage.

Requirements to provide/deliver the form: As set forth below, this form must be provided to the employer or eligible employees at the time of issuance of the policy or at renewal, as applicable.

While it is the insurer's, or a representative of the insurer's, responsibility to accurately fill out and deliver the form, these instructions acknowledge that eligible employees receive information about their health insurance primarily through their employer. The following are the permitted methods of delivery:

- a. When an insurer, or a representative of an insurer, meets in person with the eligible employee, the insurer or a representative of the insurer may hand-deliver the completed form to the eligible employee. Alternatively, the insurer, or representative of the insurer, may offer the eligible employee the following options, and shall provide the form to be delivered in the manner selected by the eligible employee:
 - 1) A printed copy deposited in the United States mail, postage pre-paid, within seven (7) days of the request;
 - 2) An electronic copy delivered to an e-mail address provided by the eligible employee;
 - 3) An electronic copy delivered via a link on the Internet;
 - 4) A copy delivered by any other means acceptable to both the insurer and the eligible employee.
- b. For an eligible employee who conducts their enrollment electronically, the insurer, or a representative of the insurer, must make the form available on the electronic site and the insurer must require the eligible employee to acknowledge receipt of the form as a necessary step to completing the enrollment application.
- c. For an enrollment application that is completed over the phone or through the mail, the insurer, or a representative of the insurer, shall offer a printed copy of the completed form within seven (7) days to the address provided by the eligible employee. Alternatively, the insurer, or representative of the insurer, may offer the eligible employee the following

options, and shall provide the form to be delivered in the manner selected by the eligible employee:

- 1) An electronic copy delivered to an e-mail address provided by the eligible employee;
- 2) An electronic copy delivered via a link on the Internet;
- 3) A copy delivered by any other means acceptable to both the insurer and the eligible employee.

- d. When an insurer issues a policy or delivers a certificate the form shall be included with the policy or certificate and provided in the manner selected by the policy holder or certificate holder.
- e. When the policy or certificate is renewed, the insurer shall provide the form in the same manner in which the policy or certificate were provided along with the renewal documents.

An oral description of the form is not sufficient. An insurer, or a representative of the insurer, may not provide the form solely by orally explaining the form and its contents either in person or over the telephone.

Unless otherwise required by law, this form is a freestanding document and may not be incorporated into any other document that an insurer, or an insurer's representative, provides to an applicant, policy holder or certificate holder.

General Instructions: Read all instructions carefully before completing the form.

- This form must be filled out accurately and by the insurer in good faith.
- Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. Unless otherwise instructed, the insurer must use 12-point (as required by federal law) Times New Roman font, and replicate all symbols, formatting, bolding, colors, and shading exactly. Attached is an example of a blank form.
- Insurers must customize all identifiable company information throughout the document, including websites and telephone numbers.
- If there is a different amount for in-network and out-of-network expenses (such as annual deductible, additional deductibles, or out-of-pocket limits), list both amounts and indicate as such, using the terms to describe provider networks used by the insurer. 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 Answer column should show "\$2000 preferred provider, \$5,000 non-preferred provider".
- 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 shown in the example must always begin on Page 2, and the rows shown on 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.

- Footer: The footer must appear at the bottom left of every page. The insurer must insert the appropriate telephone number and website information.
- For initial forms (provided to employees in the pre-selection stage), insurers may provide both single and family information for each category, where applicable (e.g. premium, deductible, out-of-pocket limit and annual limit). For example, for the deductible category, the Answer column may show "\$2,000 Individual" in the first line, and "\$3,000 Family" in the second line". For final forms (provided to employees after selection), insurers should only include information for the relevant plan.
- For all form sections to be filled out by the insurer (particularly in the *Answers* column on page 1, and the *Your Cost and Limitations and Exceptions* columns in the chart that starts on page 2), the insurer should use plain language and present the information in a culturally and linguistically appropriate manner and utilize terminology understandable by the average individual.

Filling out the form:

Top Left Header (Page 1):

On the top left hand corner of the first page, the insurer 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**".
 - Insurers have the option to use their logo instead of the typing in the company name if the logo includes the name of the entity issuing the coverage.
 - The insurer must use the commonly known company name.

Top Right Header (Page 1):

On the top right hand corner of the first page, the insurer must show the following information:

- **First line:** After *Policy Period*, the insurer must show the beginning and end dates for the applicable policy period in the following format: "MM/DD/YYYY – MM/DD/YYYY". For example: "Policy Period: 09/15/2010 - 09/14/2011".
- **Second line:**
 - After the words "Coverage For", indicate who the policy is for (such as Individual, Individual + Spouse, Family). The insurer will use the terms used by the policy, but should ensure that the term used will make it easy for the eligible employee to compare similar types of plans.
 - After the words "Plan Type", indicate the type of insurance plan, such as HMO, PPO, POS, Indemnity, or High-deductible.

Disclaimer (Page 1):

The disclaimer should be replicated and the insurer may not vary the font size, graphic or formatting. The insurer should insert the plan's website and telephone number.

Important Questions/Answers/ Why This Matters Chart**General Instructions for the Important Questions chart:**

- This chart must always appear on Page 1, and the rows must always appear in the same order. Insurers must complete the *Answers* column for each question on this chart, using the instructions below.
- Insurers must show the appropriate language in the *Why This Matters* box as instructed in the instructions below. Insurers must replicate the language given for the *Why This Matters* box exactly, and may not alter the language.
- When responding with a list of items, use words such as “and”, “or”, or “plus” rather than using a semi-colon. For example: “Yes, \$5,000 deductible for prescription drugs and \$2,000 for occupational therapy” rather than “Yes, \$5,000 for prescription drugs; \$2,000 for occupational therapy”.

1. What Is The Premium?:*Answers column:*

- a. Instructions for the Initial Form (provided before the employee selects a plan):
 - 1) Insurers will include the following statement: “Please contact your employer for your share of the premium amount.”
 - 2) Employers will provide an addendum that defines the monthly premiums for each coverage level for each plan to support the evaluation of plans by eligible employees during the open enrollment period. This addendum should include the following premium information:
 - a) For small groups whose premiums are based on table rates, the complete rate table should be attached with a reference in the Premium box to refer to the attached rates. This will allow eligible employees to identify the premiums they would pay based on their combination of age, gender, and coverage level/tier.
 - b) For groups whose premiums are not based on age factors, premiums for each coverage level/tier available for the plan should be displayed. This will allow eligible employees to identify the premiums they would pay based on their coverage level/tier.
- b. Final Form for Group Plans (provided after the employee selects a plan)
 - 1) Insurers will include the following statement: “Please contact your employer for your share of the premium amount.”
 - 2) Employers will provide an addendum with the following premium information:
 - a) For small groups whose premiums are based on table rates, the premiums they will pay based on their combination of age, gender, and coverage level/tier should be displayed. For example: Male/Female, Age xx – xx, Coverage Tier - \$xxx per month
 - b) For groups whose premiums are not based on age factors, premiums for each coverage level/tier available for the plan should be displayed. This will allow eligible employees to identify the

premiums they would pay based on their coverage level/tier. For example: Coverage Level - \$xxx per month

Why This Matters column:

- c. The insurer must always insert the following language: “The **premium** is the amount paid for health insurance.”

2. What Is The Overall Deductible?:

Answers column:

- a. If there is no calendar year or policy period deductible, answer “\$0”.
- b. If there is a calendar year or policy period deductible, answer with the dollar amount and indicate whether it is based on a calendar year, or policy period. For example: “\$5,000 for calendar year” or “\$5,000 for policy period”.
- c. If there is a calendar year or policy period deductible, underneath the dollar amount insurers must include language specifying major categories of covered services that are NOT subject to this deductible. For example, “Does not apply to preventive care and generic drugs”.
- d. If there is a calendar year or policy period deductible, underneath the dollar amount insurers must include language listing major exceptions, such as out-of-network coinsurance, deductibles for specific services and copayments, which do not count toward the deductible. For example, “Out-of-network coinsurance and copayments don’t count toward the deductible.”
- e. Show the answer for the type of policy only. For example, if this is an individual policy, show answers only for individual. If a family policy and there is a single deductible amount for the family, show answers only for family.
- f. If portraying a family policy for which there is a separate deductible amount for each individual and the family, show the individual deductible on the first line, and the family deductible on the second line. For example, the first line may show “Individual \$2,000” and the second line may show “Family \$3,000”.

Why This Matters column:

- g. If there is no calendar year or policy period deductible, show the following language: “See the chart starting on page 2 for your other costs for services this plan covers”.
- h. If there is a calendar year or policy period deductible, show the following language: “You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy 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**.”

3. Are There Other Deductibles for Specific Services?:

Answers column:

- a. If the calendar year or policy period deductible is the only deductible, answer with the phrase “No, there are no other deductibles.” Do not answer with just one word.
- b. If there are other deductibles, answer “Yes”, then list the names and deductible amounts of the three most significant deductibles other than the annual deductible.

Significance of deductibles are determined by the insurer based on two factors: probability of use and financial impact on the employee. Examples of other deductibles include deductibles for Prescription Drug, Hospital, and Mental Health). For example: "Yes, \$2,000 for prescription drug expenses and \$2,000 for occupational therapy services".

- c. If the plan has more than three other deductibles and not all deductibles are shown, the following statement must appear at the end of the list: "There are other deductibles."
- d. If the plan has less than three other deductibles, the following statement must appear at the end of the list: "There are no other deductibles."
- e. Show the answer for the type of policy only. For example, if this is an individual policy, show answers only for individual. If this is a family policy and there is a single deductible amount for the family, show answers only for family.
- f. If portraying a family policy 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"

Why This Matters column:

- g. If there are no other deductibles, the insurer must show the following language: "Because you don't have to meet **deductibles** for specific services, this plan starts to cover costs sooner."
- h. If there are other deductibles, the insurer must show the following language: "You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services."

4. *Is There An Out-of-Pocket Limit On My Expenses?*

Answers column

- a. If there are no out-of-pocket limits, respond "No. There's no out-of-pocket limit on your expenses" on the first line. Do not respond with a one-word answer.
- b. If there is an out-of-pocket limit, respond "Yes", along with a specific dollar amount that applies in each plan year, and to each charge with a separate out-of-pocket limit on the first line. For example: "Yes. \$5,000".
- c. If there are other types of annual limits, such as annual or plan year limits on visits, services or drugs, then the insurer must show the following language on the second line: "Other limits apply -- see the chart that starts on page 2."
- d. If an individual policy, show answers only for individual. If a family policy and there is a single out-of-pocket limit for the family, show answers only for family.
- e. If a family policy, and there is a single out-of-pocket limit for each individual and a separate out-of-pocket limit for the family, show the individual out-of-pocket limit on the first line, and the family out-of-pocket limit on the second line. For example, the first line may show "Individual \$1,000" and the second line may show "Family \$3,000".

Why This Matters column:

- f. If there is an out-of-pocket limit, the insurer must show the following language: "The **out-of-pocket** limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses."

- g. If there is no out-of-pocket limit, the insurer must show the following language:
“There’s no limit on how much you could pay during a policy period for your share of the cost of covered services.”

5. ***What Is Not Included In The Out-of-Pocket Limit?***

Answers column

- a. If there is no out-of-pocket limit, indicate “This question doesn’t apply to this plan.”
- b. If there is an out-of-pocket limit, the insurer must list any major exceptions. This list must always include: premium, balance-billed charges, and health care this plan doesn’t cover. Depending on the policy, the list could also include: copayments, out of network coinsurance, deductibles, and penalties for failure to obtain pre-authorization for services. The insurer must state that these items do not count toward the limit. For example: “Copayments, premium, balance-billed charges, and health care this plan doesn’t cover.”

Why This Matters column:

- c. If there is an out-of-pocket limit, the insurer must show the following language:
“Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage.”
- d. If there is no out-of-pocket limit, the insurer must show “Not applicable because there’s no **out-of-pocket limit** on your expense.”

6. ***Is There An Overall Annual Limit On What The Insurer Pays?***

Answers column

- a. The insurer should respond “Yes” or “No” based on whether the policy has an overall annual limit.
- b. If the answer is “Yes”, the insurer should include a brief description and dollar amount of the overall annual limit. For example: “Yes. This policy has an overall annual limit of \$750,000”.
- c. If the answer is “No”, the insurer should state, “No. This policy has no overall annual limit on the amount it will pay each year.”

Why This Matters column:

- d. If there is an overall annual limit, the insurer must show the following language:
“This plan will pay for covered services only up to this limit during each policy period, even if your own need is greater. You’re responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits such as limits on the number of office visits.”
- e. If there is no overall annual limit, the insurer must show the following language:
“The chart starting on page 2 describes any limits on what the insurer will pay for *specific* covered services, such as office visits.”

7. ***Does This Plan Use A Network of Providers?:***

Answers column

- a. If this plan does not use a network, the insurer must respond, “No. This plan doesn’t use a network”. Do not use a one-word response.

- b. If the plan does use a network, the insurer must briefly explain its network policy. For example "Yes, this plan uses preferred providers. You may use health care providers that aren't preferred providers, but you may pay more."
- c. Insurers have the ability to use plan specific language when distinguishing between preferred provider and non-preferred provider or in-network and out-of-network out-of-pocket limits, etc.
- d. Include information on where to find a list of preferred providers or in-network providers, etc. For example "For a list of preferred providers, see www.insurancecompany.com or call 1-888-123-4567."
- e. ER and other exceptions to non-preferred provider requirements should add that information to answer field.
- f. Plans should highlight that some out-of-network specialists are often used by network providers (e.g., anesthesiologists).

Why This Matters column:

- g. If this plan uses a network, the insurer 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. Plans use the terms **in-network**, **preferred**, or **participating** to refer to providers in their network."
- h. If this plan does not use a network, the insurer must show the following language: "The providers you choose won't affect your costs."

8. Do I Need A Referral To See A Specialist?:

Answers column:

- a. Insurers have the ability to use plan specific language when distinguishing between preferred provider and non-preferred specialists or in-network and out-of-network out-of-pocket limits, etc.
- b. Insurers should specify whether a written or verbal approval is required to see a specialist.
- c. Insurers should specify whether specialist approval is different for different plan benefits.

Why This Matters column:

- d. If there is a referral required, the insurer must show the following language: "This plan will pay some or all of the costs to see a specialist but only if you have the plan's permission before you see the **specialist** for covered services."
- e. If there is no referral required, the insurer must show the following language: "You can see the **specialist** you choose without permission from this plan".

9. Are there services this plan doesn't cover?:

Answers column:

- a. If there are any items in the *Services Your Plan Does Not Cover* box in the on page 3 or 4, the insurer should answer "Yes". See the instructions for the *Excluded Services and Other Covered Services* section for more related information.

Why This Matters column:

- b. If there are no excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the insurer must show the language: "This plan also

- covers many other common health care services listed on page [3 or 4].” The insurer should note the correct page (3 or 4) depending on where the *Services Your Plan Does Not Cover* box appears on the form.
- c. If there are excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the insurer must show the language: “Some of the services this plan doesn’t cover are listed on page [3 or 4].” The insurer should insert the correct page (3 or 4) depending on where the *Services Your Plan Does Not Cover* box appears on the form.

Covered Services, Cost Sharing, Limitations and Exceptions

Information Box:

- 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 most plans that use a network, the insurer should fill in the blank on the 4th bullet, using the terminology that the insurer uses for “in-network” or “preferred provider”. This should be the same term as used in the heading of the far-left sub-column under the *Your Cost* column.
 - For plans that have the same cost-sharing percentage for in-network services as out-of-network services, the insurer should delete the 4th bullet and replace it with: “Your costs for [in-network] providers will be lower than [out-of-network] providers.” Insert the term used for in-network and out-of-network shown on the sub-column headers under the *Your Cost* column.
 - For non-networked plans, the insurer should delete the 4th bullet and replace it with: “Your costs are the same no matter which provider you see.”
- If any of the explanations in this box are inaccurate for the plan, then the insurer should use the chart below (in either the *Your Cost* column or the *Limitations and Exceptions* column) to show that information. For instance, if cost-sharing is not subject to the deductible (and therefore the second bullet is not accurate for this plan), then the insurer should indicate in the *Your Cost* column next to each cost-sharing charge that the charge is “not subject to the deductible”.

Chart Starting on Page 2 :

1. **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 all pages used.
2. ***Your Cost* columns:**
 - a. Insurers may vary the number of sub-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. HMOs should use two columns. Non-networked plans may use one column.
- b. Insurers should insert the terminology used in the policy to title the sub-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. Insurers should be aware that consumer testing has demonstrated that consumers more readily understand the terms “In-Network” and “Out-of-Network”. The sub-headings should be deleted for non-networked plans with only one column.
 - c. The columns should appear from left to right, from most in-network to most out-of-network. For example, if a 3-column format is used, the sub-columns might be labeled (from left to right) “In-Network Preferred Provider,” “In-Network Provider,” and then “Out-of-Network Provider.”
 - d. For HMOs providing no out-of-network benefits, the insurer 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).
 - e. Insurers must complete the responses under these sub-columns based on how the health insurance coverage covers the specific services listed in the chart.
 - 1) Fill in the costs column(s) with the co-insurance percentage, the co-payment amount, “No charge” if the employee pays nothing, or “Not covered” if the service is not covered by the plan. When referring to coinsurance, include a percentage valuation. For example: 20% coinsurance. When referring to co-payments, include a per occurrence cost. For example: \$20/visit or \$15/prescription.
 - 2) When responding with a list of items, use words such as “and”, “or”, or “plus” rather than using a semi-colon. For example: “Yes, \$5,000 deductible for prescription drugs and \$2,000 for occupational therapy” rather than “Yes, \$5,000 for prescription drugs; \$2,000 for occupational therapy”.
- 3. *Limitations and Exceptions column:***
- a. In this column, list the significant limitations and exceptions for each row. Significance of limitations and exceptions is determined by the insurer based on two factors: probability of use and financial impact on the employee. Examples include, but are not limited to, limits on the number of visits, limits on specific dollar amount paid by the insurer, prior authorization requirements, unusual exceptions to cost sharing, lack of applicability of a deductible, or a separate deductible.
 - b. The limitation and 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 \$XXX annual max.” or “No coverage for XXXX.”
 - c. If the policy requires the employee to pay 100% of a service in-network, then that should be considered an “excluded service” and should appear in the *Limitations and Exceptions* column and also appear in the *Services Your Plan Does Not Cover*

box on Page 3 or 4. 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 and Exceptions* column and the *Services Your Policy Does Not Cover* box.

- d. If there are pre-authorization requirements, the insurer must show the requirement including specific information about the penalty for non-compliance.
- e. If there are no items that need to appear in the limitations and exceptions box for a row, then the insurer should show “----none---”.
- f. For each section of the chart (for each *Common Medical Event*), the insurer has the discretion to merge the boxes in the *Limitations and Exceptions* column and display one response across multiple rows if such a merger would lessen the need to replicate comments and would save space.

4. Specific Instructions for *Common Medical Events*:

- a. *If you visit a health care provider's office or clinic:*
 - 1) If the policy covers other practitioners care (which includes chiropractic care and/or acupuncture), in the “Other practitioner office visit” row, the insurer will provide the cost-sharing for the other practitioners care in the *Your Cost* columns. For example, under in-network sub-column, the insurer may respond “20% coinsurance for chiropractor and 10% coinsurance for acupuncture”.
 - 2) If the policy does not cover other practitioners care, the insurer will show “Not Covered” in the *Your Cost* columns for *Other Practitioner Office visit*.
- b. *If you need drugs to treat your illness or condition:*
 - 1) Under the *Common Medical Events* column, provide a link to the website location where the employee can find more information about prescription drug coverage for this policy.
 - 2) Under the *Services You May Need* column, the insurer should list and complete the categories of prescription drug coverage in the policy (for example, the insurer might fill out 4 rows with the terms, “Generic drugs”, “Preferred brand drugs”, “Non-preferred brand drugs”, and “Specialty drugs”. It is recommended that insurers avoid the term “tiers” and instead use “categories” as it is more easily understood by consumers.
 - 3) Under the *Your Cost* column, insurers should include the cost-sharing for both retail and mail-order.
- c. *If you have outpatient surgery:*
 - 1) 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 and Exceptions* column. Significance of such expenses are determined by the insurer based on two factors: probability of use and financial impact on the employee. For example, an insurer might show

that the cost-sharing for the physician/surgeon fee row is “20% coinsurance”, but the *Limitations and Exceptions* might show “Radiology 50% coinsurance”.

d. *If you have a hospital stay:*

- 1) 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 in under the *Limitations and Exceptions* column. Significance of such expenses are determined by the insurer based on two factors: probability of use and financial impact on the employee. For example, an insurer might show that the cost-sharing for the facility fee row is “20% coinsurance”, but the *Limitations and Exceptions* might show “anesthesia 50% coinsurance”.

Disclosures:

The *Excluded Services and Other Covered Services*, *Your Rights to Continue Coverage*, *Your Grievance and Appeals Rights* and *Coverage Examples* sections must always appear in the order shown. 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 and Other Covered Services:

1. Each insurer 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, Non-emergency care when travelling outside the U.S., Chiropractic Care, Cosmetic Surgery, Dental care (adult), Hearing aids, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, and Weight loss programs.
2. The insurer may not add any other benefits to the *Other Covered Services* box other than the ones listed in (1) above.
3. Services that appear in the *Limitations and Exceptions* column in the chart starting on page 2 because the policy requires the employee to pay 100% of the service in-network, 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 and Exceptions* column (in the chart starting on page 2 chart) and in this *Services Your Plan Does Not Cover* box.
4. List placement must be in alphabetical order for each box. The lists must use bullets next to each item.

5. For example, if an insurer excludes all of the services on the list above (#1) except Chiropractic services, and also showed exclusion of Habilitation Services on Page 2 and exclusion of Dental care (child) on page 3, the Other Benefits Covered box would show "Chiropractic Care" and the *Services Your Plan Does Not Cover* box would show "Acupuncture, Non-emergency care when travelling outside the U.S., Cosmetic surgery, Dental care (child), Habilitation Services, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, Routine hearing tests, Weight loss programs."
6. If the insurer provides limited coverage for one of the services listed in (1) above, the limitation must be stated in the *Services Your Plan Does Not Cover* box or the *Other Benefits Covered* box. For example if an insurer provides acupuncture in limited circumstances, the statement in the *Services Your Plan Does Not Cover* box would show: "Acupuncture unless it is prescribed by a physician for rehabilitation purposes, Non-emergency care when travelling outside the U.S., Cosmetic surgery, Dental care (adult), Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, Routine hearing tests, Weight loss programs."

Your Rights to Continue Coverage:

This section must appear. Insurers must include the following items for all policies:

- "you or your employer commit fraud or intentional misrepresentations of material fact",
- "the insurer stops offering this policy or services in the state"
- "you move outside the coverage area"

Insurers must also include the following for group plans:

- "your employer/sponsor changes insurance carrier"
- "your employer cancels or non-renews your coverage"
- "your employment/sponsorship terminates and you are not eligible to continue coverage under COBRA or state law"

Your Grievance and Appeals Rights:

This section must appear. Depending on where plans are sold, identify the proper state health insurance customer assistance program and include their website and phone number.

Coverage Examples:

- a. HHS will provide all insurers with standardized data to be inserted in the "Sample care costs" section for each coverage example. HHS will also provide underlying detail that will allow carriers to calculate "You Pay" amounts, payments including: Date of Service, CPT code, Provider Type, Category, descriptive Notes identifying the specific service provided, and Allowed Amount.
- b. The "Amount owed to providers," also known as the Allowed Amount, will always equal the Total of the "Sample care costs." Each insurer must calculate cost sharing, using the detailed data provided by HHS, and populate the "You Pay" 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 coinsurance amount is estimated at \$57, the insurer would list \$60 in the appropriate “You Pay” section of the Coverage Example.

- c. Services on the template provided by HHS are listed individually for classification and pricing purposes to facilitate the population of the “You Pay” 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 insurer should apply their cost sharing and benefit features for each policy in order to complete the “You pay” section, but must leave the “Sample care costs” section as is. Examples of categories that might differ between the You Pay and Sample Care Costs sections could include, but are not limited to:
 - Payment of services based on the location where they are provided (inpatient, outpatient, office, etc.)
 - Payment of items as prescription drugs vs. medical equipment
- d. Each insurer must calculate and populate the “You pay” 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).
 1. **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
 2. **Co-pays** – those co-pays that don’t apply to the deductible
 3. **Limits or exclusions** – anything member pays for non-covered services or services that exceed plan limits.
 4. **Co-insurance** – anything 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.
- e. Each insurer must calculate and populate the “Plan pays” amount by subtracting the “You pay” total from the “Amount owed to providers” total.
- f. If all of the costs associated with the “having a baby” example are excluded under the plan, then the phrase “(maternity is not covered, so you pay 100%)” is added after the “You pay” amount. Otherwise no narrative should appear after the “You pay” amount.
- g. Insurers must use the “Questions and answers about Coverage Examples” as they appear and not alter the text, font, graphic, shading or colors [Should insurers be allowed to print in black and white?]. This should be placed immediately following the Coverage Examples.

- h. If the insurer provides coverage only for medical services (e.g., pharmacy or mental health benefits are carved out and administered by another insurer), the insurer should complete the Coverage Example for only those benefits that it covers, consistent with the features outlined on pages 1 to 4 of the Summary of Coverage. These non-covered costs for excluded services would show up under the “limits and exclusions” section of the “You Pay” table. [NOTE: Should we require inclusion of a disclaimer on the Coverage Example (and on the Summary of Coverage) that notes that certain benefits may be administered by a separate insurer? Should we also amend the instructions for the Summary of Coverage to address this issue in terms of how the benefits are described?]

Need Assistance?

Insurers should contact _____ at _____ to obtain assistance in completing these documents.

Appendix B-2
Coverage

Instructions— Individual Health Insurance

What Your Plan Covers and What it Costs
Draft Instruction Guide for
Individually Purchased or Non-Group Policies

Edition Date: July 2011

Purpose of the form: Beginning in March 2012, the Patient Protection and Affordable Care Act (PPACA) requires all health insurance issuers offering individual health insurance coverage to provide enrollees and potential enrollees an accurate summary of benefits and coverage explanation. This form does not apply to excepted benefits as defined by the Public Health Services Act (PHSA). Federal law requires this document so consumers will find it easier to compare policies and understand their coverage.

Requirements to provide the form: As set forth below, this form must be provided to an applicant, to the policyholder or to the certificate holder at the time of issuance of the policy or delivery of the certificate and to the policyholder or certificate holder at renewal, as applicable.

While it is the insurer's, or a representative of the insurer's, responsibility to accurately fill out and deliver the form, these instructions acknowledge that consumers receive information about their health insurance through three primary channels of communication: 1) insurance companies, 2) agents, and 3) solicitations made via telemarketers and the internet. The following are the permitted methods of delivery:

- a. When an insurer, or a representative of an insurer, meets in person with the potential applicant, the insurer or a representative of the insurer may hand-deliver the completed form to the individual. Alternatively, the insurer, or representative of the insurer, may offer the individual the following options, and shall provide the form to be delivered in the manner selected by the individual:
 - 1) A printed copy deposited in the United States mail, postage pre-paid, within seven (7) days of the request;
 - 2) An electronic copy delivered to an e-mail address provided by the individual;
 - 3) An electronic copy delivered via a link on the Internet;
 - 4) A copy delivered by any other means acceptable to both the insurer and the individual.
- b. For an applicant who conducts the insurance application electronically, the insurer, or a representative of the insurer, must make the form available on the electronic site and the insurer must require the applicant to acknowledge receipt of the form as a necessary step to completing the initial application process.
- c. For an insurance application that is completed over the phone or through the mail, the insurer, or a representative of the insurer, shall offer a printed copy of the completed form

within seven (7) days to the address provided by the applicant. Alternatively, the insurer, or representative of the insurer, may offer the individual the following options, and shall provide the form to be delivered in the manner selected by the individual:

- 1) An electronic copy delivered to an e-mail address provided by the individual;
- 2) An electronic copy delivered via a link on the Internet;
- 3) A copy delivered by any other means acceptable to both the insurer and the individual.

- d. When an insurer issues a policy or delivers a certificate the form shall be included with the policy or certificate and provided in the manner selected by the policy holder or certificate holder.
- e. When the policy or certificate is renewed, the insurer shall provide the form in the same manner in which the policy or certificate were provided along with the renewal documents.

An oral description of the form is not sufficient. An insurer, or a representative of the insurer, may not provide the form solely by orally explaining the form and its contents either in person or over the telephone.

If two or more applicants jointly request an insurance product or service from an insurer, the insurer may satisfy the requirement to provide this form by providing one form to those applicants jointly.

Unless otherwise required by law, this form is a freestanding document and may not be incorporated into any other document that an insurer, or an insurer's representative, provides to an applicant, policy holder or certificate holder.

General Instructions: Read all instructions carefully before completing the form.

- This form must be filled out accurately and by the insurer in good faith.
- Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. Unless otherwise instructed, the insurer must use 12-point (as required by federal law) Times New Roman font, and replicate all symbols, formatting, bolding, colors, and shading exactly. Attached is an example of a blank form.
- Insurers must customize all identifiable company information throughout the document, including websites and telephone numbers.
- If there is a different amount for in-network and out-of-network expenses (such as annual deductible, additional deductibles, or out-of-pocket limits), list both amounts and indicate as such, using the terms to describe provider networks used by the insurer. 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 Answer column should show "\$2000 preferred provider, \$5,000 non-preferred provider".
- 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 shown in the example must always begin on Page 2, and the rows shown on 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.

- Footer: The footer must appear at the bottom left of every page. The insurer must insert the appropriate telephone number and website information.
- For all form sections to be filled out by the insurer (particularly in the *Answers* column on page 1, and the *Your Cost and Limitations and Exceptions* columns in the chart that starts on page 2), the insurer should use plain language and present the information in a culturally and linguistically appropriate manner and utilize terminology understandable by the average individual.

Filling out the form:

Top Left Header (Page 1):

On the top left hand corner of the first page, the insurer 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**”.
 - Insurers have the option to use their logo instead of the typing in the company name if the logo includes the name of the entity issuing the coverage.
 - The insurer must use the commonly known company name.

Top Right Header (Page 1):

On the top right hand corner of the first page, the insurer must show the following information:

- **First line:** After *Policy Period*, the insurer must show the beginning and end dates for the applicable policy period in the following format: “MM/DD/YYYY – MM/DD/YYYY”. For example: “Policy Period: 09/15/2010 - 09/14/2011”.
- **Second line:**
 - After the words “Coverage For”, indicate who the policy is for (such as Individual, Individual + Spouse, Family). The insurer will use the terms used by the policy, but should ensure that the term used will make it easy for the consumer to compare similar types of plans.
 - After the words “Plan Type”, indicate the type of insurance plan, such as HMO, PPO, POS, Indemnity, or High-deductible.

Disclaimer (Page 1):

The disclaimer should be replicated and the insurer may not vary the font size, graphic or formatting. The insurer should insert the plan’s website and telephone number.

Important Questions/Answers/ Why This Matters Chart**General Instructions for the Important Questions chart:**

- This chart must always appear on Page 1, and the rows must always appear in the same order. Insurers must complete the *Answers* column for each question on this chart, using the instructions below.
- Insurers must show the appropriate language in the *Why This Matters* box as instructed in the instructions below. Insurers must replicate the language given for the *Why This Matters* box exactly, and may not alter the language.
- When responding with a list of items, use words such as “and”, “or”, or “plus” rather than using a semi-colon. For example: “Yes, \$5,000 deductible for prescription drugs and \$2,000 for occupational therapy” rather than “Yes, \$5,000 for prescription drugs; \$2,000 for occupational therapy”.

1. *What Is The Premium?:**Answers column:*

- Answer with the dollar amount (rounded to the closest whole dollar) and time period (such as monthly). Example: “\$[xxx] [monthly]”.
- Premium amounts may be provided in good faith by the insurer or agent.
- If a consumer is shopping for plans and has yet to fill out a health insurance application or has not yet been medically underwritten, insurers may, consistent with state law, use a base premium based on five factors: the number of people to be covered by the policy (i.e. individual or family), age, gender, smoking status, and location (zip code).

Why This Matters column:

- The insurer must always insert the following language: “The **premium** is the amount paid for health insurance.”
- If the consumer is shopping for plans and has been provided a base premium as described in (c) above, the insurer must also include the statement: “This is only an estimate based on information you’ve provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied”. This sentence should appear immediately after the sentence described in (d) above.

2. *What Is The Overall Deductible?:**Answers column:*

- If there is no calendar year or policy period deductible, answer “\$0”.
- If there is a calendar year or policy period deductible, answer with the dollar amount and indicate whether it is based on a calendar year, or policy period. For example: “\$5,000 for calendar year” or “\$5,000 for policy period”.
- If there is a calendar year or policy period deductible, underneath the dollar amount insurers must include language specifying major categories of covered services that are NOT subject to this deductible. For example, “Does not apply to preventive care and generic drugs”.
- If there is a calendar year or policy period deductible, underneath the dollar amount insurers must include language listing major exceptions, such as out-of-

network coinsurance, deductibles for specific services and copayments, which do not count toward the deductible. For example, "Out-of-network coinsurance and copayments don't count toward the deductible."

- e. Show the answer for the type of policy only. For example, if this is an individual policy, show answers only for individual. If a family policy and there is a single deductible amount for the family, show answers only for family.
- f. If portraying a family policy for which there is a separate deductible amount for each individual and the family, show the individual deductible on the first line, and the family deductible on the second line. For example, the first line may show "Individual \$2,000" and the second line may show "Family \$3,000".

Why This Matters column:

- g. If there is no calendar year or policy period deductible, show the following language: "See the chart starting on page 2 for your other costs for services this plan covers."
- h. If there is a calendar year or policy period deductible, show the following language: "You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy 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**."

3. *Are There Other Deductibles for Specific Services?:*

Answers column:

- a. If the calendar year or policy period deductible is the only deductible, answer with the phrase "No, there are no other deductibles." Do not answer with just one word.
- b. If there are other deductibles, answer "Yes", then list the names and deductible amounts of the three most significant deductibles other than the annual deductible. Significance of deductibles are determined by the insurer based on two factors: probability of use and financial impact on the consumer. Examples of other deductibles include deductibles for Prescription Drug, Hospital, and Mental Health). For example: "Yes, \$2,000 for prescription drug expenses and \$2,000 for occupational therapy services".
- c. If the plan has more than three other deductibles and not all deductibles are shown, the following statement must appear at the end of the list: "There are other deductibles."
- d. If the plan has less than three other deductibles, the following statement must appear at the end of the list: "There are no other deductibles."
- e. Show the answer for the type of policy only. For example, if this is an individual policy, show answers only for individual. If this is a family policy and there is a single deductible amount for the family, show answers only for family.
- f. If portraying a family policy 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"

Why This Matters column:

- g. If there are no other deductibles, the insurer must show the following language:
“Because you don’t have to meet **deductibles** for specific services, this plan starts to cover costs sooner.”
- h. If there are other deductibles, the insurer must show the following language:
“You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.”

4. *Is There An Out-of-Pocket Limit On My Expenses?**Answers* column

- a. If there are no out-of-pocket limits, respond “No. There’s no out-of-pocket limit on your expenses” on the first line. Do not respond with a one-word answer.
- b. If there is an out-of-pocket limit, respond “Yes”, along with a specific dollar amount that applies in each plan year, and to each charge with a separate out-of-pocket limit on the first line. For example: “Yes. \$5,000”.
- c. If there are other types of annual limits, such as annual or plan year limits on visits, services or drugs, then the insurer must show the following language on the second line: “Other limits apply -- see the chart that starts on Page 2”.
- d. If an individual policy, show answers only for individual. If a family policy and there is a single out-of-pocket limit for the family, show answers only for family.
- e. If portraying a family policy, for which there is a single out-of-pocket limit for each individual and a separate out-of-pocket limit for the family, show the individual out-of-pocket limit on the first line, and the family out-of-pocket limit on the second line. For example, the first line may show “Individual \$1,000” and the second line may show “Family \$3,000”.

Why This Matters column:

- f. If there is an out-of-pocket limit, the insurer must show the following language:
“The **out-of-pocket** limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.”
- g. If there is no out-of-pocket limit, the insurer must show the following language:
“There’s no limit on how much you could pay during a policy period for your share of the cost of covered services.”

5. *What Is Not Included In The Out-of-Pocket Limit?**Answers* column

- a. If there is no out-of-pocket limit, indicate “This question doesn’t apply to this plan.”
- b. If there is an out-of-pocket limit, the insurer must list any major exceptions. This list must always include: premium, balance-billed charges, and health care this plan doesn’t cover. Depending on the policy, the list could also include: copayments, out of network coinsurance, deductibles, and penalties for failure to obtain pre-authorization for services. The insurer must state that these items do not count toward the limit. For example: “Copayments, premium, balance-billed charges, and health care this plan doesn’t cover.”

Why This Matters column:

- c. If there is an out-of-pocket limit, the insurer must show the following language:
“Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage.”
- d. If there is no out-of-pocket limit, the insurer must show “Not applicable because there’s no **out-of-pocket limit** on your expenses”.

6. *Is There An Overall Annual Limit On What The Insurer Pays?**Answers* column

- a. The insurer should respond “Yes” or “No” based on whether the policy has an overall annual limit.
- b. If the answer is “Yes”, the insurer should include a brief description and dollar amount of the overall annual limit. For example: “Yes. This policy has an overall annual limit of \$750,000”.
- c. If the answer is “No”, the insurer should state, “No. This policy has no overall annual limit on the amount it will pay each year.”

Why This Matters column:

- d. If there is an overall annual limit, the insurer must show the following language:
“This plan will pay for covered services only up to this limit during each policy period, even if your own need is greater. You’re responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.”
- e. If there is no overall annual limit, the insurer must show the following language:
“The chart starting on page 2 describes any limits on what the insurer will pay for *specific* covered services, such as office visits.”

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

- a. If this plan does not use a network, the insurer must respond, “No. This plan doesn’t use a network”. Do not use a one-word response.
- b. If the plan does use a network, the insurer must briefly explain its network policy. For example “Yes, this plan uses preferred providers. You may use health care providers that aren’t preferred providers, but you may pay more.”
- c. Insurers have the ability to use plan specific language when distinguishing between preferred provider and non-preferred provider or in-network and out-of-network out-of-pocket limits, etc.
- d. Include information on where to find a list of preferred providers or in-network providers, etc. For example “For a list of preferred providers, see www.insurancecompany.com or call 1-888-123-4567.”
- e. ER and other exceptions to non-preferred provider requirements should add that information to answer field.
- f. Plans should highlight that some out-of-network specialists are often used by network providers (e.g., anesthesiologists).

Why This Matters column:

- g. If this plan uses a network, the insurer 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. Plans use the terms **in-network**, **preferred**, or **participating** to refer to providers in their network.”
- h. If this plan does not use a network, the insurer must show the following language: “The providers you choose won’t affect your costs.”
8. ***Do I Need A Referral To See A Specialist?:***
Answers column:
- a. Insurers have the ability to use plan specific language when distinguishing between preferred provider and non-preferred specialists or in-network and out-of-network out-of-pocket limits, etc.
 - b. Insurers should specify whether a written or verbal approval is required to see a specialist.
 - c. Insurers should specify whether specialist approval is different for different plan benefits.
- Why This Matters column:*
- d. If there is a referral required, the insurer 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.”
 - e. If there is no referral required, the insurer must show the following language: “You can see the **specialist** you choose without permission from this plan”.
9. ***Are There Services This Plan Doesn’t Cover?:***
Answers column:
- a. If there are any items in the *Services Your Plan Does Not Cover* box on page 3 or 4, the insurer should answer “Yes”. See the instructions for the *Excluded Services and Other Covered Services* section for more related information.
- Why This Matters column:*
- b. If there are no excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the insurer must show the language: “This plan also covers many common health care services listed on page [3 or 4].” The insurer should note the correct page (3 or 4) depending on where the *Services Your Plan Does Not Cover* box appears on the form.
 - c. If there are excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the insurer must show the language: “Some of the services this plan doesn’t cover are listed on page [3 or 4].” The insurer should insert the correct page (3 or 4) depending on where the *Services Your Plan Does Not Cover* box appears on the form.

Covered Services, Cost Sharing, Limitations and Exceptions

Information Box:

- 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 most plans that use a network, the insurer should fill in the blank on the 4th bullet, using the terminology that the insurer uses for “in-network” or “preferred

- provider". This should be the same term as used in the heading of the far-left sub-column under the *Your Cost* column.
- For plans that have the same cost-sharing percentage for in-network services as out-of-network services, the insurer should delete the 4th bullet and replace it with: "Your costs for [in-network] providers will be lower than [out-of-network] providers." Insert the term used for in-network providers and out-of-network providers shown on the sub-column headers under the *Your Costs* column.
 - For non-networked plans, the insurer should delete the 4th bullet and replace it with: "Your costs are the same no matter which provider you see."
 - If any of the explanations in this box are inaccurate for the plan, then the insurer should use the chart (in either the *Your Cost* column or the *Limitations and Exceptions* column) below to show that information. For instance, if cost-sharing is not subject to the deductible (and therefore the second bullet is not accurate for this plan), then the insurer should indicate in the *Your Cost* column next to each cost-sharing charge that the charge is "not subject to the deductible".

Chart starting on page 2:

1. **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 all pages used.
2. ***Your Cost* columns:**
 - a. Insurers may vary the number of sub-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. HMOs should use two columns. Non-networked plans may use one column.
 - b. Insurers should insert the terminology used in the policy to title the sub-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. Insurers should be aware that consumer testing has demonstrated that consumers more readily understand the terms "In-Network" and "Out-of-Network". The sub-headings should be deleted for non-networked plans with only one column.
 - c. The columns should appear from left to right, from most in-network to most out-of-network. For example, if a 3-column format is used, the sub-columns might be labeled (from left to right) "In-Network Preferred Provider," "In-Network Provider", and then "Out-of-Network Provider."
 - d. For HMOs providing no out-of-network benefits, the insurer 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).

- e. Insurers must complete the responses under these sub-columns based on how the health insurance coverage covers the specific services listed in the chart.
 - 1) Fill in the costs column(s) with 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 coinsurance, include a percentage valuation. For example: 20% coinsurance. When referring to co-payments, include a per occurrence cost. For example: \$20/visit or \$15/prescription.
 - 2) When responding with a list of items, use words such as "and", "or", or "plus" rather than using a semi-colon. For example: "Yes, \$5,000 deductible for prescription drugs and \$2,000 for occupational therapy" rather than "Yes, \$5,000 for prescription drugs; \$2,000 for occupational therapy".
3. **Limitations and Exceptions Column:**
- a. In this column, list the significant limitations and exceptions for each row. Significance of limitations and exceptions is determined by the insurer based on two factors: probability of use and financial impact on the consumer. Examples include, but are not limited to, limits on the number of visits, limits on specific dollar amount paid by the insurer, prior authorization requirements, unusual exceptions to cost sharing, lack of applicability of a deductible, or a separate deductible.
 - b. The limitation and 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 \$XXX annual max." or "No coverage for XXXX."
 - c. If the policy 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 and Exceptions* column and also appear in the *Services Your Plan Does Not Cover* box on Page 3 or 4. 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 and Exceptions* column and the *Services Your Plan Does Not Cover* box.
 - d. If there are pre-authorization requirements, the insurer must show the requirement including specific information about the penalty for non-compliance.
 - e. If there are no items that need to appear in the limitations and exceptions box for a row, then the insurer should show "----none----".
 - f. For each section of the chart (for each *Common Medical Event*), the insurer has the discretion to merge the boxes in the *Limitations and Exceptions* column and display one response across multiple rows if such a merger would lessen the need to replicate comments and would save space.
4. **Specific Instructions for Common Medical Events:**
- a. *If you visit a health care provider's office or clinic:*

- 1) If the policy covers other practitioners care (which includes chiropractic care and/or acupuncture), in the "Other practitioner office visit" row, the insurer will provide the cost-sharing for the other practitioners care in the *Your Cost* columns. For example, under the in-network sub-column, the insurer may respond "20% coinsurance for chiropractor and 10% coinsurance for acupuncture".
 - 2) If the policy does not cover other practitioners care, the insurer will show "Not Covered" in the *Your Cost* columns for *Other Practitioner Office visit*.
- b. *If you need drugs to treat your illness or condition:*
- 1) 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 policy.
 - 2) Under the *Services You May Need* column, the insurer should list and complete the categories of prescription drug coverage in the policy (for example, the insurer might fill out 4 rows with the terms, "Generic drugs", "Preferred brand drugs", "Non-preferred brand drugs", and "Specialty drugs". It is recommended that insurers avoid the term "tiers" and instead use "categories" as it is more easily understood by consumers.
 - 3) Under the *Your cost* column, insurers should include the cost-sharing for both retail and mail-order.
- c. *If you have outpatient surgery:*
- 1) 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 and Exceptions* column. Significance of such expenses are determined by the insurer based on two factors: probability of use and financial impact on the consumer. For example, an insurer might show that the cost-sharing for the physician/surgeon fee row is "20% coinsurance", but the *Limitations and Exceptions* might show "Radiology 50% coinsurance".
- d. *If you have a hospital stay:*
- 1) 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 in under the *Limitations and Exceptions* column. Significance of such expenses are determined by the insurer based on two factors: probability of use and financial impact on the consumer. For example, an insurer might show that the cost-sharing for the facility fee row is "20% coinsurance", but the *Limitations and Exceptions* might show "anesthesia 50% coinsurance".

Disclosures:

The *Excluded Services and Other Covered Services*, *Your Rights to Continue Coverage*, *Your Grievance and Appeals Rights* and *Coverage Examples* sections must always appear in the order shown. 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 and Other Covered Services:

1. Each insurer 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, Non-emergency care when travelling outside the U.S., Chiropractic Care, Cosmetic Surgery, Dental care (adult), Hearing aids, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, and Weight loss programs.
2. The insurer may not add any other benefits to the *Other Covered Services* box other than the ones listed in (1) above.
3. Services that appear in the *Limitations and Exceptions* column in the chart starting on page 2 because the policy requires the consumer to pay 100% of the service in-network, 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 and Exceptions* column (in the chart starting on page 2) and in this *Services Your Plan Does Not Cover* box.
4. List placement must be in alphabetical order for each box. The lists must use bullets next to each item.
5. For example, if an insurer excludes all of the services on the list above (#1) except Chiropractic services, and also showed exclusion of Habilitation Services on Page 2 and exclusion of Dental care (child) on page 3, the Other Benefits Covered box would show “Chiropractic Care” and the *Services Your Plan Does Not Cover* box would show “Acupuncture, Non-emergency care when travelling outside the U.S., Cosmetic surgery, Dental care (child), Habilitation Services, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, Routine hearing tests, Weight loss programs.”
6. If the insurer provides limited coverage for one of the services listed in (1) above, the limitation must be stated in the *Services Your Plan Does Not Cover* box or the Other Benefits Covered box. For example if an insurer provides acupuncture in limited circumstances, the statement in the *Services Your Plan Does Not Cover* box would show: Acupuncture unless it is prescribed by a physician for rehabilitation purposes, Non-emergency care when travelling outside the U.S., Cosmetic surgery, Dental care (adult),

Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, Routine hearing tests, Weight loss programs.”

Your Rights to Continue Coverage:

This section must appear. Insurers must include the following items:

- “you commit fraud or intentional misrepresentations of material fact”,
- “the insurer stops offering this policy or services in the state”
- “you move outside the coverage area”

Insurers must also include the following for association plans:

- “your employer/sponsor changes insurance carrier”

Your Grievance and Appeals Rights:

This section must appear. Depending on where plans are sold, identify the proper state health insurance customer assistance program and include their website and phone number.

Coverage Examples:

- a. HHS will provide all insurers with standardized data to be inserted in the “Sample care costs” section for each coverage example. HHS will also provide underlying detail that will allow carriers to calculate “You Pay” amounts, payments including: Date of Service, CPT code, Provider Type, Category, descriptive Notes identifying the specific service provided, and Allowed Amount.
- b. The “Amount owed to providers,” also known as the Allowed Amount, will always equal the Total of the “Sample care costs.” Each insurer must calculate cost sharing, using the detailed data provided by HHS, and populate the “You Pay” 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 coinsurance amount is estimated at \$57, the insurer would list \$60 in the appropriate “You Pay” section of the Coverage Example.
- c. Services on the template provided by HHS are listed individually for classification and pricing purposes to facilitate the population of the “You Pay” section. HHS specifies the Category used to roll up detail costs into the “Sample care cost” categories section. Some plans may classify that service under another category and should reflect that difference accordingly. The insurer should apply their cost sharing and benefit features for each policy in order to complete the “You pay” section, but must leave the “Sample care costs” section as is. Examples of categories that might differ between the You Pay and Sample Care Costs sections could include, but are not limited to:
 - Payment of services based on the location where they are provided (inpatient, outpatient, office, etc.)
 - Payment of items as prescription drugs vs. medical equipment

- d. Each insurer must calculate and populate the “You pay” 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).
1. **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
 2. **Co-pays** – those co-pays that don’t apply to the deductible
 3. **Limits or exclusions** – anything member pays for non-covered services or services that exceed plan limits.
 4. **Co-insurance** – anything 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.
- e. Each insurer must calculate and populate the “Plan pays” amount by subtracting the “You pay” total from the “Amount owed to providers” total.
- f. If all of the costs associated with the “having a baby” example are excluded under the plan, then the phrase “(maternity is not covered, so you pay 100%)” is added after the “You pay” amount. Otherwise no narrative should appear after the “You pay” amount.
- g. Insurers must use the “Questions and answers about Coverage Examples” as they appear and not alter the text, font, graphic, shading or colors [Should insurers be allowed to print in black and white?]. This should be placed immediately following the Coverage Examples.
- h. If the insurer provides coverage only for medical services (e.g., pharmacy or mental health benefits are carved out and administered by another insurer), the insurer should complete the Coverage Example for only those benefits that it covers, consistent with the features outlined on pages 1 to 4 of the Summary of Coverage. These non-covered costs for excluded services would show up under the “limits and exclusions” section of the “You Pay” table. [NOTE: Should we require inclusion of a disclaimer on the Coverage Example (and on the Summary of Coverage) that notes that certain benefits may be administered by a separate insurer? Should we also amend the instructions for the Summary of Coverage to address this issue in terms of how the benefits are described?]

Need Assistance?

Insurers should contact _____ at _____ to obtain assistance in completing these documents.

Appendix C-1

Why This Matters language for "Yes" Answers

Health Plan Name: Insurance Company 1

What This Plan Covers & What It Costs

Policy Period: 9/15/2010 - 9/14/2011
Coverage for: Individual | Plan Type: HMO



This is not a policy. You can get the policy at www.insurancecompany.com/HMO1500 or by calling 1-800-XXX-XXXX.

A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why This Matters:
What is the premium?	\$	The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible?	\$	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy 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. \$	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. \$	The out-of-pocket limit is the most you could pay during a policy period 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?		Even though you pay these expenses, they don't count toward the out-of-pocket limit. So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the insurer pays?	Yes. \$	This plan will pay for covered services only up to this limit during each policy period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes.	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. Plans use the term in-network, preferred, or participating for providers in their network.
Do I 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 the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 3.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com

If you aren't clear about any of the terms used in this form, see the Glossary at www.insurancecompany.com

Appendix C-2 Why This Matters language for "No" Answers

Health Plan Name: Insurance Company 1

What This Plan Covers & What it Costs

Policy Period: 9/15/2010 - 9/14/2011

Coverage for: Individual | Plan Type: HMO

**This is not a policy.** You can get the policy at www.insurancecompany.com/HMO1500 or by calling 1-800-XXX-XXXX.

A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions		Answers	Why This Matters:
What is the premium?	\$		The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible?	\$		See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	No.		Because you don't have to meet deductibles for specific services, this plan starts to cover costs sooner.
Is there an out-of-pocket limit on my expenses?	No.		There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket limit.		Not applicable because there's no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the insurer pays?	No.		The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	No.		The providers you choose won't affect your costs.
Do I need a referral to see a specialist?	No.		You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	No.		This plan also covers many common health care services listed on page 3.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.comIf you aren't clear about any of the terms used in this form, see the Glossary at www.insurancecompany.com.

FINAL (pg) - NO), 11/16/10 1 of 4

Appendix D Guide for Coverage Examples Calculations

BOBSF Individual PPO Plan

Breast Cancer - Plan Year 2 (2009)

DRAFT

	A	B	C
1	Description of condition (brief description of major services)		Instructions to Insurers: Do not modify this tab. The numbers shown here roll up from the Scenario tab. Transfer this label to the Summary of Coverage exactly as shown here.
2	Sample care costs:		Instructions for HHS:
3	Office visits & procedures	\$0	HHS to provide this label exactly as they want it to appear on the Summary of Coverage.
4	Radiology	\$0	HHS to reuse existing sample care cost categories unless a new category is required.
5	Laboratory tests	\$0	HHS to specify no more than 11 sample care cost categories as space on the page with 12 point font dictates.
6	Hospital charges	\$0	All of these costs roll up from the Scenario tab; HHS to confirm these totals match to the Scenario tab.
7	Inpatient medical care	\$0	
8	Outpatient surgery	\$0	
9	Chemotherapy	\$0	
10	Radiation therapy	\$0	
11	Prostheses (wing)	\$0	
12	Pharmacy	\$0	
13	Mental health	\$0	
14	Total	\$0	This total must match the total on the Scenario tab; HHS to confirm it matches before issuing to insurers.
15	Assumptions		
16	The following are assumptions that all health plan carriers make to calculate the scenario.		
17	Standard Assumptions		
18	These assumptions are standard across all scenarios. (HHS to apply these assumptions regardless of scenario.)		
19	Costs do not include premiums.		
20	Condition was not an excluded as a pre-existing condition.		
21	There are no other medical expenses for any member covered under the plan.		
22	All care is in-network. No out-of-network charges or any other variation in Sample Care Costs.		
23	All services occur in same policy period.		
24	All prior authorizations were obtained.		
25	All services were deemed medically necessary.		
26	All costs (allowed amount, sample care costs, member costs) greater than \$100 are rounded to the nearest hundred dollars.		
27	All costs (allowed amount, sample care costs, member costs) less than \$100 are rounded to the nearest ten dollars.		
28	All medications are covered as generic equivalents if available.		
29	All care is in-network and considered first tier (or the tier associated with the lowest level of cost sharing), for those products that incorporate tiered provider networks.		
30	Special Assumptions		
31	These assumptions are specific to this scenario only. (HHS to specify special assumptions.)		
32	[HHS to supply any assumptions that are specific to this scenario]		

DRAFT

Breast Cancer - Plan Year 1 (2008)

BCBSF Individual PPO Plan

A	B	C	D	E	F	G	H
Medical Condition:							
Condition Name							
<p>Note: Services on this tab are listed individually for classification and pricing purposes to facilitate the population of the "Sample care costs" section. HHS specifies the Category in order to roll up costs into that category in the "Sample care costs" section so that those costs are uniform across all carriers and plans. However, some plans may classify that service under another category. The insurer should apply their cost sharing and benefit features for each policy in order to complete the "You pay" section, but must leave the "Sample care costs" section as is. Examples of cost sharing and benefit features include, but are not limited to:</p> <ul style="list-style-type: none"> • Payment of services based on the location where they are provided (inpatient, outpatient, office, etc.) • Payment of items as prescription drugs vs. medical equipment <p>Instructions to HHS for Completing the Columns:</p> <p>Date of Service - include Month/Day of service so insurers understand the order in which services are rendered. Do not include year.</p> <p>Diagnosis Code - include the ICD code for each service</p> <p>CPT Code - include the CPT code for each service</p> <p>Provider Type - use one of the types listed on the "Provider Types" tab to classify each service by provider</p> <p>Category - use one of the categories listed on the "Sample Care Cost Categories" tab to classify each service so they roll up into the broader cost categories on the "Label and Assumptions" tab</p> <p>Notes - freeform field to include any special notes for that service</p> <p>Allowed Amount - include the total cost for each service that would be owed to providers that insurers will use to calculate cost-sharing</p>							
3	Date of Service	Diagnosis Code	CPT Code	Provider Type	Category	Notes	Allowed Amount
4	Total						0.00 - This amount must appear in the first tab
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							

DRAFT

BCBSF Individual PPO Plan Breast Cancer - Plan Year 2 (2009)

A		B
1	Provider Type	
2	The following are the provider types to use on the "Scenario" tab ~ "Provider Type" column to classify each service by provider type. This aids the insurers in applying benefits to each service.	
3		
4	Provider Type	What providers are covered under this Provider Type and other notes:
5	Primary	Primary Care Physician or non-Specialist
6	Specialist	Cardiology, Dermatology, Neurology, etc.
7	Alternative Provider	Chiropractor, Acupuncturist, etc.
8	Outpatient Facility	
9	Inpatient Facility	
10	Pharmacy Retail	
11	Pharmacy Mail Order	
12	Pharmacy Administered	All prescriptions reimbursable under a Pharmacy plan that are administered in a provider's office or hospital
13	Emergency Room	
14	Home Health	
15	Skilled Nursing Facility	
16	Ambulance	

Sample Care Cost Categories

The following are the sample care cost categories to use on the "Scenario" tab ~ "Category" column to classify each service so that they roll up to the same sample care cost categories in the Coverage Example label on the "Label and Assumptions" tab. This facilitates consistency between the

Category	What services are covered under this Category and other notes:
Office visits & procedures	Includes services by all physicians (primary care, specialist, etc.) and alternative providers (chiropractor, acupuncture, etc.)
First office visit	Applies to maternity scenario only; other scenarios would use "Office visits & procedures"
Anesthesia	
Chemotherapy	
Circumcision	
Emergency care	
Home health care	Includes emergency room facility charges, physician services, ambulance transportation
Hospital charges	Facility charges for inpatient/outpatient services; discharge management
Hospital charges (baby)	Applies to maternity scenario only; other scenarios would use "Hospital charges"
Hospital charges (mother)	Applies to maternity scenario only; other scenarios would use "Hospital charges"
Inpatient medical care	Services by physicians, surgeons, anesthesiologists, etc.
Laboratory tests	Includes blood work
Medical equipment & supplies	Includes durable medical equipment, orthotics, prosthetics
Mental health	
Outpatient surgery	Physician and facility charges
Pharmacy	Includes all prescription drugs (generic, brand/preferred, non-preferred) which are not administered in a hospital, physician's office or other facility
Radiation therapy	
Radiology	Includes radiology and imaging procedures, CT, MRI, Ultrasounds, x-rays
Rehabilitation services	Includes provision of treatment at any facility
Routine obstetric care	Applies to maternity scenario only; typically a bundled payment
Skilled nursing care	
Vaccines, other preventive	

Appendix E

Uniform Glossary of Coverage and Medical Terms

Glossary of Health Insurance and Medical Terms

- This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate. You can get a copy of the policy at [www.insurancecompany.com] or you may call [1-800-xxx-xxxx].
- **Bold** text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

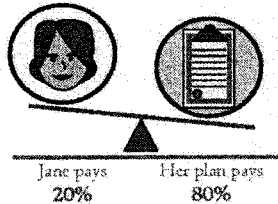
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you.

Co-insurance

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

**Complications of Pregnancy**

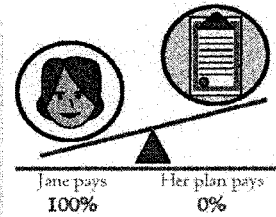
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

**Durable Medical Equipment (DME)**

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services received in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

OMB Control Numbers 1545-XXXX,
1210-XXXX, and 0938-XXXX
(expires XX/XX/XXXX)

Grievance

A complaint that you communicate to your health insurer or **plan**.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care

Health care services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to providers who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network

The facilities, providers and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or **plan**, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance

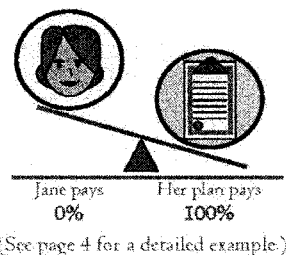
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

Physician Services

Health care services a licensed medical physician (M.D., – Medical Doctor or D.O., – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage

Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500 Co-insurance: 20% Out-of-Pocket Limit: \$5,000

