

_____, 2010

Honorable Kathleen Sebelius
Secretary of Health and Human Services

Dear Secretary Sebelius:

We are pleased to provide you standard definitions and standards for the summary of benefits and coverage for your review and consideration. These documents (enclosed) are the product of the Consumer Information (B) Subgroup established by the National Association of Insurance Commissioners (NAIC), pursuant to §1001 (adding § 2715 to the Public Health Service Act) of the Patient Protection and Affordable Care Act (PPACA).

The PPACA requires a consultation with the NAIC and a working group composed of health care professionals, patient advocates and other qualified individuals. The NAIC appointed a “group composed of representatives of health insurance-related, consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.” The NAIC created the Consumer Information (B) Subgroup and appointed a diverse membership, bringing together individuals representing the interests and expertise you requested. A complete list of the Subgroup’s membership is enclosed for your reference.

The Subgroup met for over 120 hours. The Subgroup created two teams, one focused on standard definitions and the other on the standards for the summary of benefits and coverage. Both teams met, in person or by conference call, more than 25 times. Each meeting and conference call lasted for 2 to 6 hours. Each was open to other interested individuals and parties and provided opportunity for comment and feedback from non-members. Each call had approximately 100 people participating, which is relatively high compared to most NAIC-related work. This demonstrates a high interest and involvement from a broad range of interested parties from around the nation. Members of the Subgroup, representing different perspectives, were appointed as “leads” to develop definitions, the explanation of coverage document, and instructions. Drafts were then fully discussed by the Subgroup team, revised, and further refined. Many changes were made in response to feedback from non-Subgroup members throughout the process.

The Subgroup sought to create consumer friendly and linguistically and culturally appropriate definitions for each of the statutorily dictated terms and also developed definitions for other terms the Subgroup deemed important for consumer understanding of the summary of benefits and coverage documents. These definitions are designed to meet the “plain language” requirement of the law that will aid the understanding of consumers.

To gain a better understanding of both "plain language" and "linguistically and culturally appropriate" statutory requirements, the Subgroup held hearings to receive expert testimony on both issues. Members of the Subgroup representing ethnic minority constituencies with relatively high rates of limited English proficiency (LEP) testified,

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providing recommendations how to create tools and materials that will serve diverse communities. Their presentations underscored that consumer-centered information is not "one size fits all" and that cultural and language backgrounds influence one's understanding and must be considered in translation. They strongly advised that testing and assessment be done in consultation with representative consumer organizations. Due to resource and time constraints, translations and further consumer group testing by the Subgroup was not an option. Federal regulators should consider providing translated and culturally appropriate material that, where feasible, has been developed through focus group testing.

Most of the definitions were reviewed by individuals who are expert in the areas of consumer communication and comprehension. Additionally, consumer testing, with a number of focus groups was performed by two separate organizations: Consumers Union and America's Health Insurance Plans (AHIP). Both reports are attached. The summary of coverage form and glossary documents were revisited and revised based on the feedback from consumer testing. Some revisions were also made based on feedback through the public comment period. Additionally, insurers tested the forms, throughout the process, to understand the functionality of the documents.

In developing the standards for the summary of benefits and coverage, the Subgroup sought to provide information to assist consumers in understanding the complex world of health care financing and delivery. This provides important information needed in order to make informed buying decisions. By necessity, the summary of benefits and coverage lacks some of the detail found in the health insurance policy or certificate and, in some sections, the standards for the summary of benefits and coverage refers the consumer to the health insurance policy or certificate for more information. We have attached some sample insurance contract language, as an addendum to this letter, to highlight the differences in the language and approach. For self-insured plans, consumers only receive a summary of benefits and coverage and may go to their employer to obtain more detailed information about their plan.

We recognize the law requires inclusion of a statement of whether the plan provides minimum essential coverage and covers at least 60% of total allowed costs of benefits (bronze level). Since standards for essential health benefit coverage have not yet been established by the Secretary, the Subgroup's recommendation does not include such a statement in the coverage summary at this time. The Subgroup recommends that insurers be required to include such a statement (developed by the Subgroup) on and after January 1, 2014, when qualified health plans must meet these essential health benefit requirements.

The summary of benefits and coverage document is intended to be a freestanding document. Insurers will complete the document for their benefit plans in accordance with the requirements of PPACA. The form is intended to be used for both individual, small and large group insurers. We have developed one set of instructions for individually purchased and non-group insurers and another set for all group insurance products. There may be additional changes required to the forms and instructions for large self-funded

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employer plans and for HMOs, but those changes have not yet been formulated in the attached documents.

As supplementary standardized documents, these are not designed to preempt stricter state requirements that apply to benefit summaries and insurance contracts. Further, we are assuming that states will be permitted, through your rule issuance process, to promulgate additional requirements for health insurance issuers if a state determines it is in the best interests of its residents. States understand that they may add requirements not precluded by federal law.

While these recommendations address key deliverables set forth in the law, we expect to provide additional recommendations. The Subgroup in its on-going and future work will consider the design and content of the Coverage Facts, additional definitions, and standard enrollment application for exchanges. The Subgroup is fully committed to continue discussions with your team to develop a workable approach for the coverage facts label that promotes transparency and empowers consumers to make more informed decisions about their coverage options.

In addition, we recognize that it is likely that future opportunities to improve the summary and instructions will be identified once the final documents are implemented and put into practice for thousands of insurance policy forms and for millions of consumers. We anticipate that changes could improve the documents' usefulness for consumers and the need for additional instructions to help insurers more accurately complete the forms. Because the Subgroup has gained extensive experience during the development of these documents, we believe we are uniquely qualified to consider and facilitate future changes to the summary of benefits and coverage, as well as to the instructions. We propose that the Subgroup be utilized to monitor issues identified by consumers, carriers, and employer health plans, as these documents are implemented. Further, we recommend that upon review and discussion of these issues, the Subgroup may propose needed modifications or clarifications to the documents for your consideration.

We thank you for the opportunity to collaborate with you on this important project and look forward to a continued dialogue as you continue to establish the groundwork for the full implementation of PPACA.

Sincerely,

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Superintendent
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Co-Chair, Consumer Information Subgroup

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Co-Chair, Consumer Information Subgroup

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11/15/2010

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EXAMPLES OF DEFINITIONS

From insurance contracts in Florida, Indiana, Maryland, Maine, Missouri and Vermont

Emergency Service Health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, that the absence of immediate medical attention could reasonably be expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Placing the Member's physical and/or Mental Health in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part.

Examples of illnesses or conditions that may require Emergency Services include, but are not limited to: heart attack, stroke or severe hypertensive reaction, coma, blood or food poisoning, severe bleeding, shock, obstruction (airway, gastrointestinal or urinary tract), and allergic or acute reactions to drugs. (Insurance company A policy 1 and Insurance company A policy 2)

Emergency services has the meaning stated in Health-General Article, §19-701, Annotated Code of Maryland. (Maryland Comprehensive Standard Health Benefit Plan - Small Group Market)

HG 19-701: (e) "Emergency services" means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- (1) Placing the patient's health in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

Emergency Care or Emergency Room Services - Health Care Services and supplies necessary for the treatment of an Emergency. (Missouri Insurance Company A)

Emergency Care - Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law, that may include, but will not be limited to, services provided in a licensed Hospital's emergency facility, that are needed to evaluate or Stabilize an individual in an Emergency. (Missouri Insurance Company B)

Medical Emergency Services - You always have coverage for care in a Medical Emergency. A Referral from your PCP is not needed. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed in your Schedule of Benefits. Please remember that if you are hospitalized, you must call the Plan at [1-800xxxxxxx] within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required. Your PCP will help to arrange for any follow-up care you may need. Your PCP will help to arrange for any follow-up care you may need. (Insurance company B HMO Maine)

Medical Emergency Services means those health care services that are provided in an emergency facility or setting after the onset of a Sickness or Injury that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. placing the Insured Person's physical and/or mental health in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

(Insurance company C)

Medical Emergency means the sudden and unexpected onset of a medical or psychiatric condition or an in medical care could reasonably be expected to endanger your life or result in serious injury or disability.

Emergency medical condition means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. Placing the member's physical or mental health in serious jeopardy; or
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Emergency services means health care items and services furnished or required to evaluate and treat an emergency medical condition.

E. For emergency services, the covered person shall pay:

- (1) A \$100 copayment, which the carrier shall waive if the covered person is admitted to the hospital; and
- (2) For coinsurance the:
 - (a) Amount applicable for indemnity or exclusive provider under Regulation .04F of this chapter; or
 - (b) In-network amount for preferred provider, point-of-service and triple option point-of-service under Regulation .04F of this chapter. (Maryland Comprehensive Standard Health Benefit Plan - Small Group Market)

Emergency – An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

Inpatient Stay One period of continuous, Inpatient confinement. An Inpatient stay ends when you are discharged from the facility in which you were originally confined. However, a transfer from one acute care Hospital to another acute care Hospital as an Inpatient when medically necessary is part of the same stay. (Insurance company A policy 1)

(Hospitalization) Inpatient Stay One period of continuous, inpatient confinement. An inpatient stay ends when you are discharged from the facility in which you were originally confined. However, a transfer from one acute care hospital to another acute care hospital as an inpatient when medically necessary is part of the same stay. (Insurance company A policy 2)

No definition of "Hospitalization" (Insurance company B HMO Maine)

(Hospitalization) Confined/Confinement means an Insured Person's Medically Necessary admission to and subsequent continued stay in a Hospital or skilled nursing facility as an overnight bed patient and a charge for room and board is made. (Insurance company C)

Partial Hospitalization means treatment in which an individual receives at least seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

(This part below is not part of a definition, but part of a section in the contract on "medical necessity")

Examples of hospitalization and other Health Care Services that are not Medically Necessary include, but are not limited to: completed; testing that has no clear indication 3. staying in the Hospital because supervision in the home, or care in the home, is not available or is inconvenient; or being hospitalized for any Service which could have been provided adequately in an alternate setting (e.g., HO department); or 4. inpatient admissions to a Hospital, Skilled Nursing Facility, or any other facility for the purpose of Custodial Care, convalescent care, or any other Service primarily for the convenience of the patient, his or her family members or a Provider.

"Partial hospitalization" means the provision of medically directed intensive or intermediate short-term psychiatric treatment for a period of less than 24 hours but more than 4 hours in a day for an individual patient in a hospital, psychiatric day-care treatment center, or community mental health facility. (Maryland Comprehensive Standard Health Benefit Plan - Small Group Market)

Inpatient Stay - An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility. (Missouri Company A]

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. This does not apply to a Member who is placed under observation for fewer than 24 hours. (Missouri Company B)

Medically Necessary Health Care Health care services or products provided to a Member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of “best practices” in the medical profession; and
- Not primarily for the convenience of the Member or Physician or other health care practitioner.

(Insurance company A policy 1 and Insurance company A policy 2)

Medically Necessary or Medical Necessity Health care services or products provided to a Member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of best practices in the medical profession; and
- Not primarily for the convenience of the enrollee or physician or the other health care practitioner.

(Insurance company B HMO Maine)

Medically Necessary or Medical Necessity means health care services or products provided to an Insured Person for the purpose of preventing, diagnosing or treating a Sickness, Injury or disease or the symptoms of a Sickness, Injury or disease in a manner that is:

1. Consistent with generally accepted standards of medical practice;
2. Clinically appropriate in terms of type, frequency, extent, site and duration;
3. Demonstrated through scientific evidence to be effective in improving health outcomes;
4. Representative of “best practices” in the medical profession; and
5. Not primarily for the convenience of the Enrollee or Physician or other health care practitioner

(Insurance company C)

Medically Necessary or Medical Necessity

Means that, with respect to a Health Care Service, a Physician, exercising prudent clinical judgment, provided the Health Care Service to you for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that the Health Care Service was:

1. In accordance with Generally Accepted Standards of Medical Practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease; and

3. Not primarily for your convenience, or that of your Physician or other health care Provider, and not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostics results as to the diagnosis or treatment of your illness.

Note: It is important to remember that any review of Medical Necessity by us is solely for the purpose of determining coverage or benefits under this Booklet and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of Medical Necessity in this Booklet as determined by us. In applying the definition of Medical Necessity in this Booklet, we may apply our coverage and payment guidelines then in effect. You are free to obtain a Service even if we deny coverage because the Service is not Medically Necessary; however, you will be solely responsible for paying for the Service.

“Medically-necessary care” means health care services, including diagnostic testing, preventative services and aftercare, that are appropriate in terms of type, amount, frequency, level, setting, and duration to the member’s diagnosis or condition. Medically-necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation; and

1. help restore or maintain the member’s health; or
2. prevent deterioration of or palliate the member’s condition; or
3. prevent the reasonably likely onset of a health problem or detect an incipient problem.

Medically Necessary

Health Care Services that are ordered by a health provider, without which there would be significant risk of a serious deterioration and/or a significant impairment that, if not treated, could seriously affect one’s ability to function within his or her normal environment. Although some Health Care Services are medically acceptable, they may not be medically necessary. Health Care Services need to be -

Medically appropriate and necessary to meet the basic health needs of the Member;

Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service;

Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan;

Consistent with the diagnosis of the conditions; and

Of demonstrated medical value. Medically Necessary does not include care that is provided primarily for the convenience of the Member or a health provider, or care that is rendered more frequently than that accepted as medically appropriate by the medical profession (Missouri Company A)

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations. (Missouri Company B)

Medically Necessary/ Medical Necessity - An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by Us to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member’s condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;

- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention (“cost effective” does not mean lowest cost);
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member’s family or the Provider.
- Not otherwise subject to an Exclusion under this Certificate.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

Provider A licensed health care institution, facility, or agency. Only the following Providers are eligible for payment under this Contract:

- Acute-care Hospitals
- Skilled Nursing Facilities
- Rural Health Centers
- Home Health Agencies
- Ambulatory Surgery Centers
- Hospices
- Community Mental Health Centers
- Substance Abuse Treatment Facilities
- Licensed Pharmacies
- Acute Care Psychiatric and Rehabilitation Hospitals
- Independent Laboratories
- Freestanding Imaging Centers
- Family Planning Agencies
- Durable Medical Equipment Providers
- Home Infusion Providers
- Other Providers that have written participating agreements with us
- Other Providers, as required by law

(Insurance company A policy 1 and Insurance company A policy 2)

(Provider) **Plan Provider** - Providers of health care services that are under contract with us to provide care to Members. Plan Providers include, but are not limited to hospitals; Skilled Nursing Facilities; and medical professionals including: physicians, psychiatrists, nurse practitioners, physician assistants, certified nurse midwives, certified registered nurse anesthetists, registered first nurse assistants, dentists, independent practice dental hygienists, chiropractors, and licensed mental health professionals, including psychologists, clinical social workers, marriage and family therapists, psychiatric/mental health advanced registered nurse practitioners, alcohol and drug counselors, clinical mental health counselors, and pastoral psychotherapists/counselors (except when providing services to a member of his or her church or congregation in the course of his or her duties as a pastor, minister or staff person). Plan Providers are listed in the Provider Directory.

Non-Plan Provider A provider of health care services that is not under contract with us to provide care to Members. (Insurance company B HMO Maine)

Provider – No definition of provider is in the policy, however there is the following definition of “Physician”:

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license, including a nurse practitioner or certified nurse midwife, nurse first assistant and a licensed clinical professional counselor. (A member of the Insured Person's Immediate Family will not be considered a Physician.)

(Insurance company C)

Provider means any facility, person or entity recognized for payment by BCBSF under this booklet.

Out-of-Network Provider means a Provider who, at the time Health Care Services were rendered:

1. Did not have a contract with us to participate in NetworkBlue but was participating in our Traditional Program; or
2. Did not have a contract with a Host Blue to participate in its local PPO Program for purposes of the BlueCard (Out of State) PPO Program but was participating, for purposes of the BlueCard (Out-of-State) Program, as a BlueCard (Out-of-State) Traditional Program Provider, or
3. Did have a contract to participate in NetworkBlue but was not included in the panel of Providers designated by us to be In-Network for your Plan; or
4. Did not have a contract with us to participate in NetworkBlue or our Traditional Program; or
5. Did not have a contract with a Host Blue to participate for purposes of the BlueCard (Out-of-State) Program as a BlueCard (Out-of-State) Traditional Program Provider.

Primary care provider means a health care provider who, within that provider's scope of practice as defined under the relevant state licensing law, provides primary care services, and who is designated as a primary care provider by a managed care organization.

"Network" means providers who have entered into a provider service contract with a carrier to provide services on a preferential basis.

"Out-of-network option" means an additional benefit offered by an insurer or nonprofit health service plan that:

(a) Permits a covered person enrolled in an exclusive provider delivery system to receive any healthcare service that would be covered from network providers also to be covered when received from non-network providers; and

(b) Conditions the payment of benefits as required under Insurance Article, §14-205.1, Annotated Code of Maryland.

"Provider" means a health care practitioner or a health care facility licensed or otherwise authorized by law to provide health care services.

Network or Network Provider

When used to describe a provider of Health Care Services, this means a provider that has a participation agreement in effect with Us or with Our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network Provider for only some of Our products or in certain areas. In this case, the provider will be a Network Provider for the Health Services, products and areas included in the participation agreement, and a Non-Network Provider for other Health Services, products and areas. The participation status of providers will change from time to time (Missouri Company A)

Non-Network Provider

A Provider who is not contracted with Company A Health Plans. (Missouri Company A)

Physician

Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law. Please note that any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that We describe a provider as a Physician does not mean that Benefits for services from that provider are available to You under this Policy (Missouri Company A)

Network Provider - A Provider who has entered into a contractual agreement or is being used by Us, or another organization, which has an agreement with Us, to provide Covered Services and certain administration functions for the Network associated with this Certificate. (Missouri Company B)

Non-Network Provider - A Provider who has not entered into a contractual agreement with Us for the Network associated with this Certificate. Providers who have not contracted or affiliated

with Our designated Subcontractor(s) for the services they perform under this Certificate are also considered Non-Network Providers. (Missouri Company B)

Primary Care Physician (“PCP”) – A Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care. (Missouri Company B)

Provider – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID Card. (Missouri Company B)

Physician - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiroprapist (surgical foot specialist) or ophthalmologist (Missouri Company B)

Out-of-Pocket Limits

Your annual out-of-pocket expenses for your Deductible and Coinsurance are limited. Please refer to your Summary of Benefits for Annual Out-of-Pocket Limits that apply to services provided by PCPs and for Self-Referred services. Once you reach the Annual Out-of-Pocket Limit, no further Deductibles or Coinsurance apply for the remainder of the Calendar Year. The Copayment amounts continue to apply after the Annual Out-of-Pocket Limits are met. Copayments, penalties for not obtaining pre-admission review, and amounts over our Maximum Allowance do not count toward the out-of-pocket limit. There are separate out-of-pocket limits for care provided by or authorized by your Primary Care Physician PCP and care covered at the Self-Referred Benefit Level. Coinsurance you pay for services under the PCP Benefit Level do not count toward the out-of-pocket limit for Self-Referred care. Deductibles and Coinsurance you pay for Self-Referred services do not count toward your out-of-pocket limit under the PCP Benefit Level. (Insurance company A policy 1)

Annual Out-of-Pocket Limit The limit on the Deductible and Coinsurance you pay each year. After you meet the annual out-of-pocket limit, you pay no further Deductible or Coinsurance for most services. (Insurance company A policy 2)

Out-of-Pocket Maximum An Out-of-Pocket Maximum is a limit on the amount of Copayments, Coinsurance and Deductibles that you must pay for Covered Benefits in a [calendar year] [Plan Year]. Member Cost Sharing for outpatient prescription drugs maybe excluded from your Out-of-Pocket Maximum. The Out-of-Pocket Maximum, if applicable to your Plan, is specified in your Schedule of Benefits.

Please Note: Charges above the Usual, Reasonable and Customary Charge never apply to the Out-of-Pocket Maximum.

FOR EXAMPLE: If your plan has an individual Out-of-Pocket Maximum of \$1,000, this is the most Member Cost Sharing you will pay for out-of-pocket costs for that [calendar year] [Plan Year]. As an example, the Out-of-Pocket Maximum can be reached by the following: \$500 in Deductible expenses, \$400 in Coinsurance expenses and \$100 in Copayment expenses.

(Insurance company B HMO Maine)

(Out of Pocket Limit) **Coinsurance Maximum** means the total amount of Covered Expenses an Insured Person must pay after application of the Coinsurance per each Calendar Year. Once this maximum is met, Covered Expenses remaining thereafter for the same Calendar Year will be paid at 100%. **Deductibles and Copayments do not count toward meeting the Coinsurance Maximum.** The Coinsurance Maximum is shown in the POLICY SCHEDULE.

(Insurance company C)

Out-of-Pocket Maximums

Individual out-of-pocket maximum

Once you have reached the individual out-of-pocket maximum amount listed in the Schedule of Benefits, you will have no additional out-of-pocket responsibility for the remainder of that Benefit Period and Covered Services rendered during the remainder of the Benefit Period will be paid at 100 percent of the Allowed Amount.

Family out-of-pocket maximum

If your plan includes a family out-of-pocket maximum, once your family has reached the family out-of-pocket maximum amount listed in the Schedule of Benefits, neither you nor your covered family members will have any additional out-of-pocket responsibility for the remainder of that Benefit Period and Covered Services rendered during the remainder of that Benefit Period will be paid at 100 percent of the Allowed Amount. The maximum amount any one Covered Person in your family can contribute toward the family out-of-pocket maximum is the amount applied toward the individual out-of-pocket maximum. Please see your Schedule of Benefits for more information.

Note: The Deductible and Coinsurance amounts, including those for Covered Prescription Drugs and Supplies, will accumulate toward the out-of-pocket maximums. Any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount will not accumulate toward the out-of-pocket maximums.

Coinsurance

Coinsurance is the percentage of Our allowance that You must pay for Your care. You may also be responsible for other costs for Your care such as a Deductible. See Section 5 (Your Cost for Covered Services). (Missouri Company A)

Copayment

A Copayment is a fixed amount of money You pay, if applicable, when You receive Covered Services. See Section 5 (Your Cost for Covered Services). (Missouri Company A)

Lifetime Maximum – The maximum dollar amount We will pay for Covered Services during your lifetime. [Nonstandard - While Prescription Drugs do not accumulate toward the Lifetime Maximum, once the Lifetime Maximum has been reached, no additional benefits for Prescription Drugs will be paid.] (Missouri Company B)

Benefit Period Maximum – The maximum that We will pay for specific Covered Services during a Benefit Period. (Missouri Company B)

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the “Claims Payment” section. (Missouri Company B)

Deductible – The dollar amount of Covered Services, listed in the Schedule of Benefits, which you must pay for before We will pay for those Covered Services in each Benefit Period. (Missouri Company B)

Coinsurance - A specific percentage of the Maximum Allowable Amount for Covered Services indicated in the Schedule of Benefits that you must pay. Coinsurance normally applies after the Deductible, if applicable, that you are required to pay. See the Schedule of Benefits for any exceptions. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments. (Missouri Company B)

Copayment – A specific dollar amount of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. The Copayment does not apply to any Deductible or Coinsurance that you are required to pay. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or amount charged by the Provider. (Missouri Company B)

Coinsurance - A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. Coinsurance normally applies after the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions.

Deductible – The dollar amount of Covered Services, listed in the Schedule of Benefits, which you must pay for before We will pay for those Covered Services in each Benefit Period.

Glossary

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](tel: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.

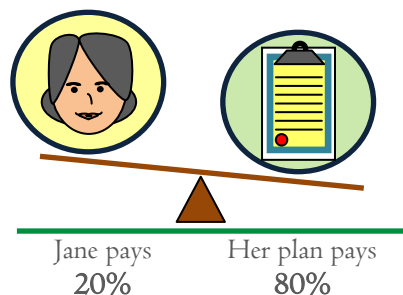
Balance Billing

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.



(See page 4 for a detailed example.)

Complications of Pregnancy

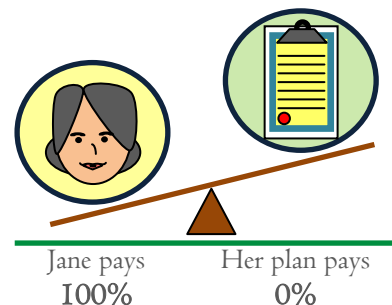
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

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.



(See page 4 for a detailed example.)

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.

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

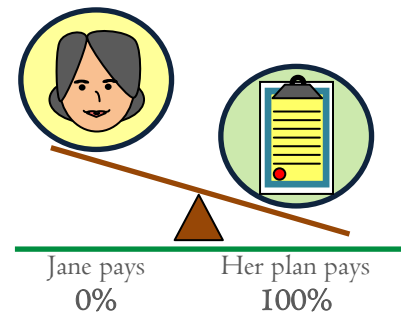
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

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

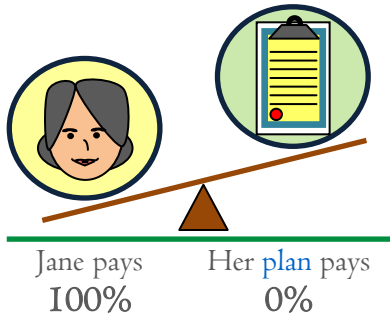
Jane's Plan Deductible: \$1,500

Co-insurance: 20%

Out-of-Pocket Limit: \$5,000

January 1st
Beginning of Policy Period

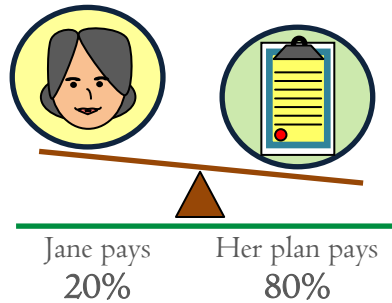
December 31st
End of Policy Period



Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.
Office visit costs: \$125
Jane pays: \$125
Her plan pays: \$0

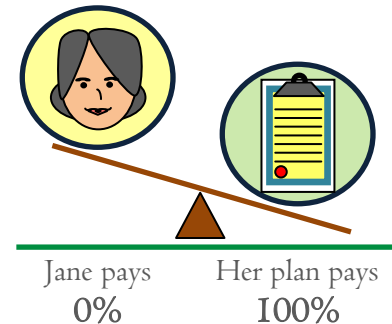
more costs



Jane reaches her \$1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.
Office visit costs: \$75
Jane pays: 20% of \$75 = \$15
Her plan pays: 80% of \$75 = \$60

more costs



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: \$200
Jane pays: \$0
Her plan pays: \$200

Blank Summary of Benefits and Coverage

What This Plan Covers & What it Costs



This is not a policy. You can get the policy at _____ or by calling _____.
 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 _____ or visit us at www._____

If you're unclear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Covered Services, Cost Sharing, Limitations and Exception



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. 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 coinsurance 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, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Provider	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)			
If you need drugs to treat your illness or condition More information about drug coverage is at www._____	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs (e.g., chemotherapy)			
If you have outpatient surgery	Facility fee (example, ambulatory surgery center)			
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services			
	Emergency medical transportation			
	Urgent care			

Questions: Call _____ or visit us at [www._____](#)

If you're unclear about any of the terms used in this form, see the Glossary at [www.insuranceterms.gov](#).

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Provider	Provider	
If you have a hospital stay	Facility fee (example: hospital room)			
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you become pregnant	Prenatal and postnatal care			
	Delivery and all inpatient services			
If you have a recovery or other special health need	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	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.)			
•	•	•	•
•	•	•	•

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

Questions: Call _____ or visit us at www._____

If you're unclear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Coverage Facts:

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.XXXXXXXXXXXXXX.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.XXXXXXXXXXXXXX.gov.

Questions: Call _____ or visit us at [www._____](http://www._____.com)

If you're unclear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Sample Completed Summary of Benefits and Coverage



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 ?	\$280 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 ?	\$1,500 Doesn't apply to office visits, preventive care, and generic drugs.	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; \$500 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. \$5,000	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 ?	Copayments, premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the insurer pays?	No. There is no <i>overall</i> annual limit, but see page 2 for <i>specific</i> limits on covered services.	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 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 ?	Yes. You need a referral to see a specialist.	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.insuranceterms.gov.

Covered Services, Cost Sharing, Limitations and Exception



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. 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 coinsurance 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, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		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	\$35 copay/visit	Not Covered	————— none —————
	Specialist visit	\$50 copay/visit	Not Covered	————— none —————
	Other practitioner office visit	30% coinsurance for chiropractor and 20% coinsurance for acupuncture	Not Covered	————— none —————
	Preventive care/screening/immunization	\$35 copay/visit	Not Covered	No charge for mammograms at a participating provider
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	————— none —————
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	————— none —————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions	Generic drugs	\$15 copay (retail); \$30 copay (mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 31-60 day supply (mail order prescription)
	Preferred brand drugs	\$40 copay (retail); \$80 copay (mail order)	Not Covered	
	Non-preferred brand drugs	\$60 copay (retail); \$120 copay (mail order)	Not Covered	
	Specialty drugs (e.g., chemotherapy)	Covered	Not Covered	
If you have outpatient surgery	Facility fee (example, ambulatory surgery center)	30% coinsurance	Not Covered	_____ none _____
	Physician/surgeon fees	30% coinsurance	Not Covered	_____ none _____
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	_____ none _____
	Emergency medical transportation	30% coinsurance	Not Covered	_____ none _____
	Urgent care	\$50 copay/visit	Not Covered	_____ none _____
If you have a hospital stay	Facility fee (example: hospital room)	30% coinsurance	Not Covered	_____ none _____
	Physician/surgeon fee	30% coinsurance	Not Covered	_____ none _____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$50 copay/visit	Not Covered	_____ none _____
	Mental/Behavioral health inpatient services	30% coinsurance	Not Covered	_____ none _____
	Substance use disorder outpatient services	\$50 copay/visit	Not Covered	_____ none _____
	Substance use disorder inpatient services	30% coinsurance	Not Covered	_____ none _____
If you become pregnant	Prenatal and postnatal care	30% coinsurance	Not Covered	_____ none _____
	Delivery and all inpatient services	30% coinsurance	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.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have a recovery or other special health need	Home health care	30% coinsurance	Not Covered	60 visits per calendar year
	Rehabilitation services	30% coinsurance	Not Covered	60 consecutive day period per instance of illness or injury
	Habilitation services	30% coinsurance	Not Covered	————— none —————
	Skilled nursing care	30% coinsurance	Not Covered	60 days per calendar year
	Durable medical equipment	30% coinsurance	Not Covered	Covered up to \$1,000 per calendar year
	Hospice service	30% coinsurance	Not Covered	————— none —————
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	————— none —————
	Glasses	Not Covered	Not Covered	————— none —————
	Dental check-up	Not Covered	Not Covered	————— none —————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)		
<ul style="list-style-type: none"> • Bariatric surgery • Non-emergency care when traveling outside the U.S. • Cosmetic surgery 	<ul style="list-style-type: none"> • Dental care (Adult) • Infertility treatment • Long-term care • Private-duty nursing 	<ul style="list-style-type: none"> • 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.)
<ul style="list-style-type: none"> • Acupuncture • Chiropractic care • Hearing aids

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 Facts:

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.XXXXXXXXXXXXXX.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.XXXXXXXXXXXXXX.gov.

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.

***Why This Matters* language for "Yes" Answers (Page 1 of
Summary of Benefits and Coverage)**



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 <i>specific</i> 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.

Why This Matters Language for “No” Answers
(Page 1 of Summary of Benefits and Coverage)



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 services this plan covers.
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.

Instruction Guide for Insurers -- Individually Purchased and Non-Group Policies

What Your Plan Covers and What it Costs

Draft Instruction Guide for Individually Purchased or Non-Group Policies

Edition Date: March 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, \$5,000non-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

- 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:

- a. Answer with the dollar amount (rounded to the closest whole dollar) and time period (such as monthly). Example: “\$[xxx] [monthly]”.
- b. Premium amounts may be provided in good faith by the insurer or agent.
- c. 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:

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

- 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 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 services this plan covers.”

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

- 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*, *Coverage Facts*, *Your Rights to Continue Coverage* and *Your Grievance and Appeals Rights* 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.”

Coverage Facts:

[No instructions at this time]

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.

Instruction Guide for Insurers -- Group Policies

What Your Plan Covers and What it Costs

Draft Instruction Guide for Group Policies

Edition Date: March 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 *Services Your Plan Does Not Cover and Other Covered Services* section may appear on Page 3 or Page 4, but must always immediately follow the chart starting

- 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 services this plan covers.”

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*, *Coverage Facts*, *Your Rights to Continue Coverage* and *Your Grievance and Appeals Rights* 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.”

Coverage Facts:

[No instructions at this time]

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.