Increasing Knowledge of Rare Disease Health Care Coverage

What is a Summary of Benefits?

A Summary of Benefits is a document provided by health insurance companies that outlines the key features and details of a health plan's coverage. It is designed to give you a clear understanding of what the plan covers, does not cover, and the associated costs.

Key elements typically included in a Summary of Benefits are:

- **Covered services:** A list of medical services and treatments that are included under the plan. This typically includes doctor visits, hospital stays, prescription drugs, and preventive care.
- **Costs:** Information on costs such as premiums, deductibles, copayments, and coinsurance that you are responsible for paying.
- **Out-of-pocket maximum:** The maximum amount you would have to pay out of your own pocket during a coverage period (usually a year). After you reach your out-of-pocket maximum, the plan pays 100% of the covered services.
- **Network information:** Details about the network of health care providers that the plan covers. This includes whether you can see out-of-network providers and at what cost.
- **Limitations and exclusions:** Any specific services or treatments that are not covered under the plan.
- **Prior authorization requirements:** Information about which services require approval from the insurance company before they are covered.

The Summary of Benefits and coverage will include a standardized health plan comparison tool for consumers called "coverage examples." The coverage examples illustrate how a health insurance policy (plan) would cover care for common benefits scenarios. Using clear standards and guidelines provided by the Center for Consumer Information and Insurance Oversight (CCIIO), plans and issuers will simulate claims processing for each scenario. This allows consumers to see an illustration of the coverage they receive under a plan.

CCIIO sample summary of benefits and coverage

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