Checklist for
Summary of Benefits and Coverage for Rx Only Plans

Full Name of Employer: _____

Full Name of Plan: _____

Coverage Period: _____

Who is Coverage for (ex. Employee Only, Family, etc.): _____

Website where Plan info can be accessed: _____

Phone Number where Plan info can be obtained: _____

Website where Defined Terms can be accessed: _____

Phone Number where Defined Terms info can be obtained: _____

IMPORTANT QUESTIONS

What is the overall deductible?
(if there is no deductible, please skip to the next section)

Deductible • Individual • Family Unit	

Deductible does not apply to preventive care…:

	Out-of-network coinsurance
	Out-of-network copayments
	Other:
	Other:
	Other:
	Other:

Are there any other deductibles for specific services?
(if NO, please skip to the next section)

Please list the 3 most significant deductibles…
• • •

Is there an out-of-pocket limit on my expenses?
(if NO, please skip to the next section)

Out-of-pocket maximum • Individual • Family Unit	

What is not included in the out-of-pocket limit?
(if the Plan has not OOP limit, please skip to the next section)

	Copayments
	Out-of-network coinsurance
	Deductibles
	Penalties for failure to obtain pre-authorization for services
	Other:
	Other:
	Other:

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

The plan will reimburse medical expenses up to:	$_____

Does this plan use a network of providers?

☐ YES ☐ NO

Do I need a referral to see a specialist?

☐ YES ☐ NO

Are there services this plan doesn't cover?

☐ YES ☐ NO

Important Information:
(please choose one)

	This plan may encourage you to use in-network providers by charging you lower deductibles, copayments, and coinsurance amounts.
	Your cost sharing does not depend on whether a provider is in a network.

COMMON MEDICAL EVENTS

Services You May Need	Your cost if you use an: In-Network Provider	Your cost if you use an: Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[_____].com or by calling [_____].			
Generic drugs	[_____]% coinsurance for retail $[_____] copayment/prescription for retail [_____]% coinsurance for mail order $[_____] copayment/ prescription for mail order	[_____]% coinsurance for retail $[_____] copayment/prescription for retail [_____]% coinsurance for mail order $[_____] copayment/ prescription for mail order	☐ ---none--- **OR** Coverage is limited to $[_____] annual max. No coverage for: _____ _____ _____ _____ *(Also list in Services Your Plan Does Not Cover)* Pre-authorization required. Failure to pre-authorize will result in a $[_____] penalty.
Preferred brand drugs	[_____]% coinsurance for retail $[_____] copayment/prescription for retail [_____]% coinsurance for mail order $[_____] copayment/ prescription for mail order	[_____]% coinsurance for retail $[_____] copayment/prescription for retail [_____]% coinsurance for mail order $[_____] copayment/ prescription for mail order	☐ ---none--- **OR** Coverage is limited to $[_____] annual max. No coverage for: _____ _____ _____ _____ *(Also list in Services Your Plan Does Not Cover)* Pre-authorization required. Failure to pre-authorize will result in a $[_____] penalty.

Non-preferred brand drugs	[_____]% coinsurance for retail $[_____] copayment/prescription for retail [_____]% coinsurance for mail order $[_____] copayment/ prescription for mail order	[_____]% coinsurance for retail $[_____] copayment/prescription for retail [_____]% coinsurance for mail order $[_____] copayment/ prescription for mail order	☐ ---none--- **OR** Coverage is limited to $[_____] annual max. No coverage for: _____ _____ _____ _____ *(Also list in Services Your Plan Does Not Cover)* Pre-authorization required. Failure to pre-authorize will result in a $[_____] penalty.
Specialty drugs	[_____]% coinsurance for retail $[_____] copayment/prescription for retail [_____]% coinsurance for mail order $[_____] copayment/ prescription for mail order	[_____]% coinsurance for retail $[_____] copayment/prescription for retail [_____]% coinsurance for mail order $[_____] copayment/ prescription for mail order	☐ ---none--- **OR** Coverage is limited to $[_____] annual max. No coverage for: _____ _____ _____ _____ *(Also list in Services Your Plan Does Not Cover)* Pre-authorization required. Failure to pre-authorize will result in a $[_____] penalty.

YOUR GRIEVANCE AND APPEAL RIGHTS

Type of Plan:
(please choose one of the following groups, and complete all information in that table that applies)

	Self-funded ERISA Plan
	Plan's Phone:

	Fully insured ERISA Plan
	Plan's Phone:

	State:
	State Department of Insurance Phone:

	Self-funded non-federal governmental group health plan
	Plan's Phone:
	TPA's Phone:

	Fully-insured non-federal governmental group health plan
	Plan's Phone:
	TPA's Phone:
	State:
	State Department of Insurance Phone:

Does the applicable State offer a consumer assistance program?
(if NO, please skip to the next section)

☐ NO ☐ YES. Contact Name & Phone: _____

LANGUAGE ACCESS SERVICES

Your document may require a foreign language notification. Please check the following website for a list of state and county requirements: http://www.cciio.cms.gov/resources/factsheets/clas-data.html

Which language, if any, must be included in your plan:

	Spanish		Tagalog
	Chinese		Navajo

Phone for customer assistance where non-English language help can be obtained: _____