Checklist for
Summary of Benefits and Coverage

Full Name of Employer: _____

Full Name of Plan: _____

Coverage Period: _____

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

Is this a: ☐ PPO Plan ☐ HMO Plan

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 use **$0**)*

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?
(if NO, please skip to the next section)

Annual Limits	

Does this plan use a network of providers?
(if NO, please skip to the next section)

Website where providers can be obtained:	
Phone number where providers can be obtained:	

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:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic			
Primary care visit to treat an injury or illness	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/visit and $[_____] 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.
Specialist visit	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/visit and $[_____] 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.

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Preventive care/ screening/ immunization	0% coinsurance	[_____] % coinsurance $[_____] copayment/visit	---none---
If you have a test			
Diagnostic test (x-ray, blood work)	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
Imaging (CT/PET scans, MRIs)	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
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.

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
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.
If you have outpatient surgery			

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Facility fee (e.g., ambulatory surgery center)	[_____]% coinsurance $[_____] copayment/ procedure	[_____]% coinsurance $[_____] copayment/ procedure	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
Physician/surgeon fees	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
If you need immediate medical attention			

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Emergency room care	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
Emergency medical transportation	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Urgent care	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
If you have a hospital stay			
Facility fee (e.g., hospital room)	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	**Out-of-Network Provider**	
Physician/surgeon fee	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
If you have mental health, behavioral health, or substance abuse needs			

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
outpatient services	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
inpatient services	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
If you are pregnant			

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Office visits	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
Childbirth/delivery professional services	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Childbirth/delivery facility services	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
If you need help recovering or have other special health needs			

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Home health care	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
Rehabilitation services	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Habilitation services	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
Skilled nursing care	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Durable medical equipment	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
Hospice service	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
If your child needs dental or eye care			

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Children's Eye exam	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.
Children's Glasses	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.

Services You May Need	Your cost if you use an:		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Children's Dental check-up	[_____]% coinsurance $[_____] copayment/ visit	[_____]% coinsurance $[_____] copayment/ visit	☐ ---none--- **OR** Coverage is limited to $[_____]/procedure and $[_____] 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.

EXCLUDED SERVICES & OTHER COVERED SERVICES

Services your plan does NOT cover:
[The items in this list below **MUST** be included in either "Services Your Plan Does NOT Cover" & "Other Covered Services."

You CAN add to the "Services Your Plan Does NOT Cover":]

	Acupuncture		Bariatric surgery
	Chiropractic care		Cosmetic surgery
	Dental care (adult)		Hearing aids
	Infertility treatment		Long-term care
	Non-emergency care when traveling outside the US		Private duty nursing
	Routine eye care (adult)		Routine foot care
	Weight loss programs		Other:
	Other:		Other:
	Other:		Other:
	Other:		Other:

Other covered services:
[You CANNOT add to this "Other Covered Services" list].

	Acupuncture		Bariatric surgery
	Chiropractic care		Cosmetic surgery
	Dental care (adult)		Hearing aids
	Infertility treatment		Long-term care

	Non-emergency care when traveling outside the US		Private duty nursing
	Routine eye care (adult)		Routine foot care
	Weight loss programs		

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: _____

Does the plan provide Minimum Essential Coverage?
(if NO, please skip to the next section)

☐ NO ☐ YES

Does this plan meet the Minimum Value Standards?
(if NO, please skip to the next section)

☐ NO ☐ YES

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: _____

COVERAGE EXAMPLES

Peg is Having a Baby (normal delivery)	
Plan's overall deductible	$[_____]
Specialist (cost sharing)	$[_____]
Hospital (facility) (cost sharing)	[_____]%
Other (cost sharing)	[_____]%
Total Example Cost	$[_____]
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$[_____]
Copays	$[_____]
Coinsurance	$[_____]
What isn't covered:	
Limits or exclusions	$[_____]
Total Peg would pay is:	**$[_____]**

Managing Joe's type 2 diabetes (a year of routine in-network care of a well-controlled condition)	
Plan's overall deductible	$[_____]
Specialist (cost sharing)	$[_____]
Hospital (facility) (cost sharing)	[_____]%
Other (cost sharing)	[_____]%
Total Example Cost	$[_____]
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$[_____]
Copays	$[_____]
Coinsurance	$[_____]
What isn't covered:	
Limits or exclusions	$[_____]
Total Joe would pay is:	**$[_____]**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
Plan's overall deductible	$[_____]
Specialist (cost sharing)	$[_____]
Hospital (facility) (cost sharing)	[_____]%
Other (cost sharing)	[_____]%
Total Example Cost	$[_____]
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$[_____]
Copays	$[_____]
Coinsurance	$[_____]
What isn't covered:	
Limits or exclusions	$[_____]
Total Mia would pay is:	**$[_____]**