The Center on Health Insurance Reforms
Georgetown University Health Policy Institute

The Policy Landscape for Helping Consumers Choose and Use Their Coverage

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Quiz Time!

BlueCross® BlueShield® Service Benefit Plan: Standard Option Coverage Period: 01/01/2015 – 12/31/2015
Summary of Benefits and Coverage Coverage for: Self Only -or- Self and Family | Plan Type: PPO

This is only a summary. Please read the FEHB Plan brochure RI 71-005 that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at www.fepblue.org/brochure or by calling 1-800-411-BLUE.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 350/Self Only $ 700/Self and Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain covered services you use. **Copayments** and **coinsurance** amounts do not count toward your **deductible**, which generally starts over January 1. When a covered service/supply is subject to a **deductible**, only the Plan allowance for the service/supply counts toward the **deductible**. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible** and which services are subject to the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Using Preferred providers: $5,000 (Self Only coverage); $6,000 (Self and Family coverage) Using Non-preferred providers: $7,000 (Self Only coverage; $8,000 (Self and Family coverage)	The **out-of-pocket limit,** or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for healthcare expenses.
What is not included in the out–of–pocket limit?	Please review Section 4 in brochure RI 71-005.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. A list of **Preferred providers** is available at fepblue.org/provider.	If you use an in-network doctor or other healthcare **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. [We use the terms **preferred** or participating for **providers** in our **network**.] See the chart starting on page 2 for how this plan pays different kinds of **providers**.
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?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See this plan's FEHB brochure for additional information about **excluded services**.

Questions: Call the phone number on the back of your ID card or visit us at www.fepblue.org/contact to find your local Plan's phone number.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.fepblue.org/sbc, or call 1-800-411-BLUE to request a copy.

FEHB

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Summary of Benefits and Coverage

- Applies to all plans: individual, employer, Marketplace plans
  - Apples-to-apples comparisons when shopping for coverage
  - Costs and rules that apply when using coverage
- Provided upon application, enrollment, when benefit or cost change prompts change in content, and upon request

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Summary of Benefits and Coverage

- Top line info: deductible, out-of-pocket limit, provider network rules
- "Common medical events" – co-pays for doc, drugs, lab tests, when prior authorization or visit limits apply
- Coverage examples: having a baby, diabetes
- Statements on minimum value, minimum essential coverage
- Changes to template will take effect in 2017

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Marketplace Function: Consumer Assistance

- Navigator program: in person assistance
  - Outreach and education
  - Enrollment and eligibility
- Complex rules, complex lives require assistance
- Going forward: funding constraints, but FFM program move to 3 year grants will help

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Marketplace Plan Tools

- Policy and other changes will improve transparency on key consumer questions for next open enrollment period
- Out-of-pocket costs
  - SBCs will be tailored to reflect cost-sharing reductions
  - Out-of-pocket cost calculator in FFM

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Marketplace Plan Tools

- Provider directory: easily accessible and
  - Updated at least monthly
  - Include info on: whether taking new patients, location/contact info, specialty, institutional affiliation, medical group
- Drug formulary: easily accessible and
  - Updated with each change
  - Include info on: tier, restrictions on access
- For both: machine-readable format

Marketplace Function: Certify QHPs

- In certifying QHPs, exchanges are to act "in the interests of" consumers
- SMBs as active purchasers:
  - Limit number of plan or benefit designs to simplify plan choice
  - Standardize benefits to facilitate apples-to-apples comparisons

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