Your Financial Security Network

October 19, 2011

CC:PA:LPD:PR (REG-140038-10)
Room 5205
Internal Revenue Service
PO Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Comments Regarding the Summary of Benefits and Coverage

Dear Sirs:

American Fidelity Assurance Company ("AFA") respectfully submits the following comments as requested in the Notice of Proposed Rulemaking regarding the implementation of provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), ("Affordable Care Act") related to the Summary of Benefits and Coverage ("SBC").

Founded in 1960, AFA is one of the largest private, family-owned life and health insurance companies in the United States. AFA provides insurance products and administrative record-keeping services (including services for Code section 125 cafeteria plans and Health Reimbursement Arrangements) to education employers, automobile dealers and associations, health care providers and municipalities across the United States.

As explained more fully below, our comments focus on three areas of concern. First, we believe the agencies should craft an explicit exception for grandfathered individual policies offering non-comprehensive medical coverage that are not available for sale. Second, if the agencies are unwilling to craft such an exception, significant revisions must be made to the NAIC format to address policies that offer non-comprehensive medical coverage. Finally, the proposed compliance date leaves insufficient time to prepare - compliance should not be required until at least 12 months after final regulations are issued.

Background

Most of AFA's insurance products are not subject to the requirements of the Affordable Care Act because AFA does not provide traditional major medical coverage (hereafter "comprehensive medical coverage"). However, AFA acquired a small number of individual policies providing non-comprehensive medical coverage through a reinsurance agreement effective July 1, 1998, under which AFA agreed to maintain policies originally held by American Standard Life

("ASL"), an Oklahoma-based company placed in receivership in the late 1980s.[1] Pursuant to this agreement, AFA is required to maintain the acquired policies on a guaranteed renewable basis and is prohibited from canceling the policies except for nonpayment of premium or upon a policyholder's death.

The acquired policies represent a closed block of business. AFA maintains the acquired policies, but has never offered these policies for sale. The premiums are fixed, and have never been increased. The number of policyholders is steadily shrinking through attrition. In 2005, there were 153 policyholders, but today there are only 82 policyholders. Most policyholders are eligible for Medicare – 62% of the current policyholders are age 65 or older. More than 80% of the current policyholders are age 60 or older. The youngest policyholder is age 48.

As noted, the acquired policies all provide some type of non-comprehensive medical coverage. While the acquired policies comprise 13 different policy forms, the following four categories represent the types of benefits being provided:

- ***Specific Injury/Sickness policies.*** These policies cover Medical Benefits related to a specific injury or sickness. The policies pay 80% of covered expenses after a deductible up to a maximum benefit limit. Some versions of these policies also include additional caps on Daily Hospital Benefit and Surgical Benefit related to a specific injury or sickness.

- ***Hospital Confinement policies.*** These policies cover Hospital Confinement and other specified expenses resulting from an accident or sickness. The policies pay 100% of expenses subject to an aggregate limit for all specified Hospital Services, and separate limits for specific Hospital Services. These policies also pay 100% of expenses for specified out-patient services, up to specified limits per category of service and per occurrence.

- ***Hospital/Surgical policies (with deductible).*** These policies cover Hospital and Surgical benefits subject to a deductible. The policies pay a Maximum Daily Hospital Benefit, Maximum Hospital Services Benefit and Maximum Surgical Benefit. The Daily Hospital Benefit includes a per-day dollar maximum and limit of 120 days for any one continuous period of hospital confinement. The Hospital Services Benefit pays up to a maximum benefit for any one period of hospital confinement. The Surgical Benefit pays up to a specified dollar amount per a surgical schedule.

- ***Hospital/Surgical policies (without deductible).*** These policies cover specific Hospital and Surgical expenses, without a deductible or coinsurance. The policies pay specified amounts for specific in-patient treatments, such as hospital room, operating room, anesthesia, laboratory and path services, etc. These policies cover only a few designated outpatient services.

[1] Most of the ASL policies were similarly assumed from other carriers. ASL never sold new business under any of the acquired policies.

The premiums for the acquired policies vary, depending on the policy form and the scope of coverage. The average premium for the current 82 policyholders is $36.46 per month. For purposes of the Affordable Care Act, all of the acquired policies are grandfathered and will remain grandfathered. This means, among other things, that the acquired policies will not be required to cover the essential health benefits package beginning in 2014.

Comments and Recommendations

The Affordable Care Act includes provisions requiring group health plans and health insurance issuers to furnish an SBC to participants and beneficiaries at enrollment and upon request. The proposed regulations require SBCs to be prepared in accordance with a prescribed uniform format – a format illustrated by sample templates and instructions prepared by the National Association of Insurance Commissioners ("NAIC"). The proposed compliance date for the SBC requirement is March 23, 2012.

In preparing draft SBCs for the acquired policies, we quickly learned that the NAIC format is inadequate because it does not distinguish between comprehensive and non-comprehensive medical coverage. The NAIC sample template assumes, on every page, that a policy offers comprehensive coverage. It doesn't contemplate that a health insurance issuer might have policies, like the acquired ASL policies, that offer only non-comprehensive coverage. The "one size fits all" approach advocated by the NAIC may work for policies offering comprehensive coverage. But it simply does not work when a policy offers only non-comprehensive coverage.

To illustrate our concerns with the strict requirements of the NAIC format, let's take a closer look at one of the acquired Hospital/Surgical policies (without deductible). This policy, which we designate as E0110, offers the following non-comprehensive coverage (note that we've asterisked items that are clearly addressed by the NAIC template; items without an asterisk are not addressed by the NAIC template):

1. Hospital Expense Benefits – policy pays for the following inpatient hospital expenses, not to exceed the amounts stated:

- Hospital Room* – not to exceed $60/day and limited to 365 days for any one accident or sickness
- Operating room – When confined to the hospital, policy covers full regular charge
- Anesthesia – When confined to the hospital, policy covers $40.00 for a respiratory anesthetic. $20.00 for a spinal anesthetic or $10.00 for a local anesthetic
- Lab or Pathology Services – When confined to the hospital, policy pays $15.00
- X-Rays – When confined to the hospital, policy pays $20.00 excluding dental x-ray or x-ray therapy
- Narcotics for relief of pain – When confined to the hospital, policy covers full regular charge when administered by injection
- Medicines – When confined to the hospital, policy covers expenses up to $30.00
- Surgical dressing – When confined to the hospital, policy covers full regular charge
- Casts and splints – When confined to the hospital, policy covers full regular charge

- Oxygen – When confined to the hospital, policy covers equipment and supplies up to $30.00
- Use of iron lung – When confined to the hospital, policy covers full regular charge
- Blood transfusion – When confined to the hospital, policy covers materials and services up to $50.00

2. Surgical Operations* – policy pays according to a schedule of surgical benefits

3. Nurse Expense for Accidents – policy covers actual expense up to $10/day for up to 10 days per accident

4. Home Nurse Expense for Accident or Sickness* – policy covers actual expense up to $30/day for up to 30 days for any one accident or sickness

5. Ambulance Expense* – policy covers (a) transfer service to or from a hospital for hospitalization covered under the policy, up to $10 for each ambulance trip, for no more than 2 trips as the result of one accident or sickness; and (b) emergency ambulance service due to accidental injury up to $50

6. First Aid Treatment for Minor Accidental Injuries* – actual expense for treatment, not to exceed two times the Daily Room Rate

7. Accidental Death Indemnity – Policy pays $1,000

8. Dismemberment – Policy pays $1,000 for certain losses (loss of sight or dismemberment of limbs; loss of both hands or both feet; loss of sight of both eyes; loss of one hand and one foot; loss of one hand and sight of one eye; loss of one foot and sight of one eye). Policy pays $500 for other losses (loss of one hand or one foot; loss of sight of one eye)

Here are some of the problems we encountered in drafting an SBC for policy E0110:

- The NAIC template includes a header on each page where a health insurance issuer is required to specify the "type" of coverage. But neither the header, nor any of the "Important Questions" on page 1, permit AFA to explain or clarify the distinction between comprehensive and non-comprehensive medical coverage. Nor does the NAIC template permit AFA to clarify that certain coverages under policy E0110 are available only if an individual seeks care following an accident.

- The NAIC instructions insist that a health insurance issuer include the company's website address on every page. Because of the unique nature of the acquired policies, AFA has always steered questions on these policies to a single person. If the company's direct general website address is required, there is a distinct possibility that policyholder inquiries will be misdirected.

- The NAIC instructions insist that a health insurance issuer include the text at the bottom of page 1 and the top of page 2 defining the terms co-payment and co-insurance, and

describing balance billing with an explanation that refers to an out-of-network provider. Even though the NAIC instructions permit the elimination of network references in the table of "Common Medical Events," retaining the references to out-of-network providers in the header is confusing. Note that none of the acquired policies have a network structure or co-payments, so a good portion of the NAIC's "fixed" text is irrelevant.

- The NAIC template includes a table of "Common Medical Events" on pages 2 through 4. This table assumes that a policy provides comprehensive medical coverage, so the list of events is very broad, and the number of items listed per event is limited. For example, the table entry entitled "If you have a hospital stay" offers room to discuss only two types of services – hospital room and physician/surgeon fees. But policy E0110 includes 12 categories of hospital benefits, only two of which are specifically addressed by the NAIC template.

- The NAIC instructions insist that health insurance issuers complete each item in the table of "Common Medical Events" and not add additional items. The NAIC instructions also insist that any "Limitations & Exceptions" for each item be described in the final column. Because the acquired policies offer non-comprehensive medical coverage, most of the items listed in the table are irrelevant. Of the 32 items listed, only 10 items are relevant to policy E0110. In addition, the "Limitations & Exceptions" column is not large enough to describe the fee schedule that policy E0110 uses for covered physician and surgeon services. Without providing the full fee schedule, a policyholder might assume, incorrectly, that policy E0110 covers all traditional physician and surgeon services rather than the discrete list of services that are actually covered.

- The NAIC template includes a table of "Excluded Services and Other Covered Services" on page 5. The NAIC instructions insist that health insurance issuers specifically address whether 13 types of services are "excluded" or "covered," and prohibit an issuer from adding any other benefits to the list of "Other Covered Services." Both the "Excluded Services" and "Other Covered Services" caption include a brief disclaimer – "This isn't a complete list. Check your policy for others (or other covered services)." Because the rigid NAIC instructions preclude AFA from fully describing the other services covered by policy E0110, a policyholder might assume, incorrectly, that because something isn't listed that it's covered. For example, the NAIC instructions preclude AFA from describing – in the area of the template most appropriate for this description – that policy E0110 provides certain coverage only for services incurred following accidents, but not illnesses.

- The NAIC template does not explain or address the concept of coordination of benefits ("COB"). The rigid NAIC instructions preclude AFA from describing either the COB concept, or how COB rules might apply to policy E0110.

- The NAIC template on page 7 includes "Coverage Examples" based on an assumption that comprehensive medical coverage is being provided through a PPO network. Because the "sample care costs" are prepared based on a PPO network structure, those costs will not necessarily be consistent with the non-discounted costs that a policyholder

covered by a non-comprehensive policy will experience. A bigger concern is that policyholders reviewing these examples will have no understanding of what is being allowed, and how their out-of-pocket costs were determined. This means that the "Coverage Examples" for policy E0110 will not be accurate and, more significantly, will be totally confusing for policyholders.

Strict adherence to the NAIC sample template and instructions produces an SBC for policy E0110 that:

- Steers mostly elderly policyholders to a general website instead of a more specific or dedicated website
- Fails to adequately describe the difference between comprehensive and non-comprehensive coverage
- Includes almost two dozen "Common Event" table entries of "Not covered"
- Does not permit sufficient space to describe covered hospital benefits
- Does not permit sufficient space to describe covered physician/surgeon services
- Prohibits the description of items without an asterisk, so does not permit an adequate explanation of "Other Covered Services"
- Includes woefully inadequate disclaimers for this type of non-comprehensive coverage
- Does not address COB
- Includes "Coverage Examples" that may be inaccurate and confusing

Due to the inflexible structure of the NAIC format, the result is that the SBC for policy E0110 is neither accurate nor complete. A copy of our draft SBC for policy E0110 is attached for your reference.

Comment #1 – The Agencies should craft a limited SBC exception for grandfathered policies offering non-comprehensive coverage

The SBC is intended to be a comparative shopping tool, helping consumers evaluate health plan and health insurance coverage in the marketplace. This goal is not well served when, as here, policyholders of the acquired policies will receive an SBC that is neither accurate nor complete.

Section 2792 of the Public Health Service Act provides the Secretary with broad authority to "promulgate such regulations as may be necessary or appropriate to carry out the provisions of this title." We respectfully request that the agencies consider crafting an SBC exception, or a process for seeking an exception, for policies like the acquired policies.

The criteria for such an exception might mirror some of the key attributes of the acquired policies, to wit:

- Policies offer only non-comprehensive coverage, so won't compete with comprehensive coverage
- Policies are grandfathered, so will never be expanded to cover essential health benefits
- Policies are a closed block of business, and are not offered for sale to the general public
- Policies cover a significant percentage of individuals eligible for Medicare

This exception would recognize that an SBC for the acquired policies offers little value to policyholders and may do more to confuse than to clarify. The policyholders of the acquired policies know and understand that these policies offer only non-comprehensive coverage. Most of the policyholders are eligible for Medicare today, and will not have access to individual policies in the commercial market. Thus, the efficacy of an SBC for these policyholders is questionable. If the agencies thought it would be valuable, health insurance issuers qualifying for this exception could be required to send a short model notice that explicitly states coverage is non-comprehensive. We would be happy to discuss the development of an SBC exception in further detail.

Comment #2 – If the Agencies do not craft an SBC exception, the strict NAIC format should be modified for policies offering non-comprehensive coverage

As we have discussed, the strict NAIC format assumes that a policy offers comprehensive coverage. It does not permit a health insurance issuer to adequately explain and clarify the differences between comprehensive and non-comprehensive coverage. Nor does it permit an issuer to adequately explain the benefits of a policy offering non-comprehensive coverage, including ancillary benefits such as life insurance, disability insurance, accidental death & dismemberment or other similar coverages. The result is an SBC that is incomplete and potentially misleading.

If the agencies are not willing to craft an SBC exception, then further revisions to the NAIC format should be made to facilitate accurate summaries for policies offering non-comprehensive coverage. Our experience in drafting an SBC for policy E0110 is instructive – the problem areas we have identified should be reviewed and addressed. Our focus points include:

- Flexibility to steer policyholders to specific contacts
- Flexibility to delete portions of the NAIC template that are not applicable
- Flexibility to distinguish non-comprehensive coverage from comprehensive coverage
- Flexibility to accurately describe covered benefits
- Flexibility to accurately describe non-covered benefits
- Flexibility to accurately describe coordination of benefits
- Flexibility to add disclaimers or explanations appropriate to the policies

This last point is particularly important. The acquired policies are held by a closed group of policyholders, the policies are not being offered for sale to the general public and the policies are grandfathered. AFA should be able to explain how the acquired policies originated, and how they differ from policies offering comprehensive coverage.

Comment #3 – The SBC compliance date should be delayed

The Affordable Care Act required the agencies to publish the SBC regulations by March 23, 2011. Adherence to this date would have given group health plan sponsors and health insurance issuers at least 12 months to prepare, focus-test and fine-tune their SBCs. We understand that the agencies were not able to release regulations by the statutory deadline due to NAIC delays.

Nevertheless, giving plans and issuers less time to prepare isn't a solution.

A compliance date of March 23, 2012 isn't practical or reasonable. Relying on the schedule dictated by the Affordable Care Act, group health plan sponsors and health insurance issuers assumed they would have at least a year to prepare. Even assuming that final regulations, and final versions of the SBC template and instructions, can be issued by year-end, sponsors and issuers would be left with less than three months to prepare. Policyholders deserve better. We urge you to extend the compliance date until at least 12 months after final regulations are issued.

* * *

In summary, we recommend that: (A) the agencies craft an SBC exception for the acquired policies along the lines we have discussed; (B) if an exception is not feasible, the agencies provide additional flexibility to the NAIC format to allow AFA to fully explain how coverage under the acquired policies actually works; and (C) the agencies delay the compliance date for at least 12 months after final regulations are issued.

Thank you in advance for your consideration of this request. AFA would welcome the opportunity to discuss this request in greater detail or to answer any questions that you may have. Please feel free to contact me at (405) 523-5341 or susan.relland@af-group.com if you have any questions or would like any additional information.

Respectfully submitted,

Susan Relland

Enclosure – Draft SBC for policy E0110

This is not a policy. You can get the policy at www.afadvantage.com /Plan E0110 or by calling 1-800-565-8802
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?	**$35.00** monthly	The **premium** is the amount paid for health insurance.
What is the overall deductible?	**$0**	See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	No, there are no other deductibles	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 is no out-of-pocket limit on your expenses	There is no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This question does not apply to this plan.	No applicable because there is no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	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. This plan does not use a network.	The providers you choose won't affect your costs.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist	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 4.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 co-insurance 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**.)
- Your costs are the same no matter which provider you see

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	All amounts over $120.00 maximum benefit for an accident	Coverage is limited to $120.00 per accident. No coverage for an illness condition.
	Specialist visit	All amounts over $120.00 maximum benefit for an accident	Coverage is limited to $120.00 per accident. No coverage for an illness condition
	Other practitioner office visit	All amounts over $120.00 maximum benefit for an accident	Coverage is limited to $120.00 per accident. No coverage for an illness condition
	Preventive care/screening/immunization	Not covered	———none———
If you have a test	Diagnostic test (x-ray, blood work)	Not covered as out-patient service	———none———
	Imaging (CT/PET scans, MRIs)	Not covered as out-patient service	———none———
If you need drugs to treat your illness or condition .	Generic drugs	Not covered as out-patient service	———none———
	Preferred brand drugs	Not covered as out-patient service	———none———
	Non-preferred brand drugs	Not covered as out-patient service	———none———

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
	Specialty drugs (e.g., chemotherapy)	Not covered as out-patient service	none
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	none
	Physician/surgeon fees	All amounts over benefit listed in surgical schedule in policy No benefit for physician's care.	See schedule in policy. Maximum policy benefit is $700.00
If you need immediate medical attention	Emergency room services	Not covered	none
	Emergency medical transportation	All amounts over $10.00 benefit for each accident or illness for transfer to or from any hospital. All amounts over $50.00 for each emergency transfer as the result of an accident to the nearest hospital.	Coverage is limited to a maximum benefit of $10.00 for each accident or illness for transfer to or from any hospital. Coverage is limited to a maximum benefit of $50.00 for each emergency transfer as the result of an accident to the near hospital
	Urgent care	All amounts over $120.00 maximum benefit for an accident	Coverage is limited to $120.00 per accident. No coverage for an illness condition
If you have a hospital stay	Facility fee (e.g., hospital room)	All amounts over $60.00 per day for hospital room charge.	Coverage is limited to $60.00 per day not to exceed 365 days for any one accident or sickness
	Physician/surgeon fee	All amounts over benefit listed in surgical schedule in policy No benefit for physician's care.	See schedule in policy. Maximum policy benefit is $700.00

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	——none——
	Mental/Behavioral health inpatient services	Not covered	——none——
	Substance use disorder outpatient services	Not covered	——none——
	Substance use disorder inpatient services	Not covered	——none——
If you become pregnant	Prenatal and postnatal care	Not covered	——none——
	Delivery and all inpatient services	Same as any other illness	——none——
If you have a recovery or other special health need	Home health care	All amounts over $15.00 maximum benefit per day	Coverage is limited to $15.00 per day for a maximum of 30 days.
	Rehabilitation services	Not covered	——none——
	Habilitation services	Not covered	——none——
	Skilled nursing care	Not covered	——none——
	Durable medical equipment	Not covered	——none——
	Hospice service	Not covered	——none——
If your child needs dental or eye care	Eye exam	Not covered	——none——
	Glasses	Not covered	——none——
	Dental check-up	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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- 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.)

- Non-Emergency care when traveling outside the U.S. unless charge is for an expense covered under this policy
- Private-duty nursing

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 **1-800-565-8802** or visit **www.afadvantage.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: **1-800-565-8802** or visit **www.afadvantage.com**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much insurance protection you might get from different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $10,000
- **Plan pays** $0
- **You pay** $10,000

Sample care costs:

First office visit	$100
Radiology	$300
Laboratory tests	$200
Routine obstetric care	$2,000
Hospital charges (mother)	$4,100
Hospital charges (baby)	$1,900
Anesthesia	$1,000
Circumcision	$200
Vaccines, other preventive	$200
Total	**$10,000**

You pay:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$6,600
Total	**$6,600**

Treating breast cancer
(lumpectomy, chemotherapy, radiation)

- **Amount owed to providers:** $98,000
- **Plan pays** $94,800
- **You pay** $3,200

Sample care costs:

Office visits & procedures	$4,000
Radiology	$4,000
Laboratory tests	$2,400
Hospital charges	$3,300
Inpatient medical care	$200
Outpatient surgery	$3,400
Chemotherapy	$64,000
Radiation therapy	$13,000
Prostheses (wig)	$500
Pharmacy	$2,000
Mental health	$1,200
Total	**$98,000**

You pay:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$97,800
Total	**$97,800**

Managing diabetes
(routine maintenance of existing condition)

- **Amount owed to providers:** $7,800
- **Plan pays** $6,800
- **You pay** $1,000

Sample care costs:

Office visits & procedures	$960
Laboratory tests	$300
Medical equipment & supplies	$40
Pharmacy	$6,500
Total	**$7,800**

You pay:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$7,800
Total	**$7,800**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy period.
- There are no other medical expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.