Summary of Benefits and Coverage Video Transcript

Hi, I'm Alexa Grayson, and I'm the Insurance Navigation Program Manager here at Project HEAL. I'm here to talk about the Summary of Benefits and Coverage within an insurance plan, also referred to as the SBC or SOB. We're going to talk about what it is, where to find it within an insurance plan, and how to use it, and why it's important.

The Summary of Benefits and Coverage is essentially a snapshot of a health plan's covered benefits and the cost that you may pay for those services. It is a patient's right to be given your SBC in easy-to-understand language when requested. You can find the SBC when you're enrolling in an insurance plan through the marketplace or an employer by a link or a downloadable PDF to compare when choosing between plans. If you already have insurance, you can ask a copy, ask for a copy from your insurance company or employer at any time. If you have an insurance portal, you can also find your SBC there.

Let's take a look at an example of a Summary of Benefits and Coverage and what that might look like. This is a sample graph that's taken off of the ACA Marketplace to give you an idea of the breakdown of the chart and what you might see when you're comparing plans. The SBC is also really helpful, especially on the marketplace, when you want to compare to other plans. And it's overwhelming because there are so many. So, if you have plans that are very different, maybe they're a little bit similar, you can select up to three and compare them side by side. If you are getting insurance elsewhere, outside of the marketplace, such as your job, you should also have access to something that looks like this, depending on how many insurance plans your company is offering.

So, when we start on the first page, it starts with some important questions and how to answer those. And it also gives you some more information on why these things are important. So first it talks about the deductible, what it would look like individually for just you. And if it's a family plan or you have other people on your plan, this is what the family deductible would look like. Meaning that for yourself, you'd have to meet $500 typically before insurance starts to kick in, or $1000 as a family, whichever one is met first for you individually. When you go down, it does talk about um other things that the deductible applies to. Are their services covered before you meet your deductible? It says here, yes, there's preventative care and primary care and those services are covered before you meet your deductible. So, in those cases, it would just be a copay.

It also asks, are there other deductibles for specific services? This is common for prescription drug coverage. Um, and here it tells you what that, um, what the deductible is. It's $300. So typically, $300 before a copay would kick in for your drug coverage. It also talks about the
out-of-pocket max and the out-of-pocket limit. The out of pocket max, it tells you here, similar to the deductible, where there’s an individual and family. There is an individual out of pocket max and a family out of pocket max. So, the out-of-pocket max applies.

Maybe you meet your deductible. If it’s you individually $500 your insurance kicks in, you’re paying co–pays, so that $500 counts in this $2500. You would have $2000 left after that to meet your out–of–pocket max. When you do meet your out–of–pocket max, then typically you wouldn’t have any co–pays, everything would be paid off for the remainder of the year. So, you wouldn’t owe anything to insurance. For a family, that would be $5000. So, same situation. But as a family, so maybe you’ve met $2500, but your, um, child or partner maybe hasn’t met anything towards their deductible. So if it’s a family deductible, this $2500 individually can go towards that $5000 family for your child, your partner, your parents, whoever it might be.

It does also show you if there are out of network benefits. Is there a separate out of pocket for out of network services? Typically, those deductibles are different, and they’re typically higher than if you were to go in your network because insurance is usually trying to get you to stick to preferred providers, those that they network with. It does talk about here too that you will pay less if you use a network provider, and you are able to look those up when you are applying. And then if you scroll down, it goes through all the different services that you might use. Um medically, mental health, um, common medical events is what it sticks to and most graphs, charts SBCs look pretty much like this. It breaks down the same things. Um So it talks about testing, what that might look like. You have to meet your deductible first, drug coverage if you’re having surgery, uh emergency room, urgent care. What will it look like if I have a hospital stay? What will it look like if I’m giving birth to a child? My child needs to stay there in the NICU, maybe you need to stay there for a few days. So, what will that cost look like?

It also talks about mental health and behavioral health, all plans on the insurance marketplace do have mental health coverage. They don’t all have the same amount of mental health coverage, but they do typically have something because it’s one of the 10 basic health benefits. It usually breaks it down by outpatient services and inpatient services. So this would typically be, say you’re going to eating disorder PHP - that counts as outpatient. The copay is $35, so you’d be paying $35 a day, and that $35 copay would kick in after you’ve met your deductible in most cases. And you would be paying that $35 daily until you meet your out–of–pocket max. If inpatient, this is what it looks like. And residential services are typically included in this inpatient category. It’s not very clear because it doesn’t break down all the individual levels of care like IOP, PHP, uh residential, so I like to be safe. And once I choose a plan, I like to call in and ask specific questions. What behavioral health um levels of care does my plan cover? Does that include residential?
Another thing um that is something that's not usually included on here. Sometimes it will be in this section, or this section um might be nutrition therapy that is actually under a medical benefit rather than um psychiatric or mental health. So that's something also that often I suggest calling to check in on um if there is nutrition session coverage? Are there any exclusions? Is there coverage for eating disorders? Is it only for specific diagnoses? Is there a limited amount of sessions that you can have during the year? Some plans will allow you one initial session or one or two follow-ups and that's all they will pay for, for the year. Or is it unlimited? So, you definitely want to give them a call and ask about those.

So, in summary, that is what the SBC looks like. Um You can typically find it when you're applying on the marketplace. Uh There's some more breakdowns here. It gives you some examples of different situations and what that cost breakdown might look like and how that applies with the deductible, the copay, uh what's not covered. And again, you can find this on the marketplace, you can find it. Um if you're not applying for the first time or you need to come back to it, typically, you will get this sent to you in a packet when you're signing up or the most common way that it's found is by going into an insurance portal that's usually available for most plans. If you're not sure how to check this, if it's your employer, um then you can check in with them or HR to see how you can access this or you can check in with your insurance company. But that is pretty much the summary on the Summary of Benefits and Coverage.