Health Insurance Fine Print Analysis

Document-grounded demonstration using a real, publicly styled Summary of Benefits and Coverage (SBC).

IMPORTANT DEMONSTRATION NOTICE

This is a sample report prepared to demonstrate FinePrintCheck's reporting format. It is NOT an analysis produced by the live FinePrintCheck agent, NOT a coverage determination, and NOT legal, medical, financial, or insurance advice. The supplied SBC is a sample document with placeholder contact details; it is not evidence of an active policy or current benefits.

Document reviewed

Field	Value
Source document	2020-SBC-Sample.pdf (5 pages)
Plan shown	Insurance Company 1: Plan Option 1
Plan type / coverage	PPO / Family
Coverage period shown	January 1 - December 31, 2022
Scope	Only the supplied SBC; full plan terms were not provided

What this example demonstrates

A concise plan overview followed by high-impact coverage conditions, possible payment problems, material ambiguities, questions for the insurer, and document limitations. All quoted policy facts and figures below are traceable to the five-page SBC.

01 Policy summary

Plan name: Insurance Company 1: Plan Option 1. Carrier shown: Insurance Company 1. Plan type: PPO. Coverage: Family. Effective date: 01/01/2022; end date: 12/31/2022. (SBC p. 1)

Plain-language summary

The sample PPO distinguishes in-network and out-of-network care and generally imposes higher member cost sharing outside the network. It shows a $500 individual / $1,000 family overall deductible, plus separate $300 deductibles for prescription drugs and occupational therapy. The plan also requires specialist referrals and preauthorization for certain services. Missing preauthorization for listed services may reduce benefits by 50% of the total service cost. The SBC repeatedly directs readers to full policy terms that were not supplied.

At-a-glance figures

Provision	In network / overall	Out of network
Overall deductible	$500 individual; $1,000 family	Not separately specified
Out-of-pocket maximum	$2,500 individual; $5,000 family	$4,000 individual; $8,000 family
Special deductibles	$300 prescription drugs; $300 occupational therapy	Network-specific application not established

Key qualification

The SBC is expressly a summary. The premium is supplied separately, and the full terms, definitions and additional limitations are not included. Accordingly, this report does not claim to determine every applicable benefit or exception.

SOURCE: SBC pp. 1-2; source document is a sample SBC, not the full contract.

02 Critical points: authorization and referrals

HIGH | Specialist visit requires preauthorization

The SBC lists a $50 in-network specialist copay and 40% out-of-network coinsurance, and states that preauthorization is required. Without it, benefits could be reduced by 50% of the total cost of the service. This is a potential payment reduction, not an expressly stated automatic claim denial.

Recommended action: obtain the required referral and confirm preauthorization before the specialist visit; request written clarification of how any reduction is calculated.

SOURCE: SBC p. 2, Specialist visit; p. 2, referral question.

HIGH | Outpatient surgery facility preauthorization

For the outpatient surgery facility fee, the SBC shows a $100/day in-network copay and 40% out-of-network coinsurance. It also specifies preauthorization and a possible 50%-of-total-cost benefit reduction if authorization is missing.

Recommended action: verify authorization for the facility component separately from the physician and anesthesia components.

SOURCE: SBC p. 2, Outpatient surgery rows.

HIGH | Hospital-stay facility preauthorization

Hospital facility fees are listed at 20% in-network coinsurance and 40% out-of-network coinsurance. The same potential 50%-of-total-cost reduction appears when required preauthorization is not obtained.

SOURCE: SBC p. 3, Hospital stay / facility fee.

HIGH | Hospice preauthorization

Hospice is listed at 20% in-network and 40% out-of-network coinsurance; the SBC also identifies a preauthorization requirement and possible benefit reduction when it is missing.

SOURCE: SBC p. 3, Hospice services.

03 Critical points: network and member cost

HIGH | Network provider may use an out-of-network laboratory

The SBC explicitly warns that an in-network provider might use an out-of-network provider for some services, such as lab work. A member may face higher cost sharing and potential balance billing as described in the SBC. Confirm each provider involved before non-emergency care.

SOURCE: SBC p. 1, network provider question.

HIGH | Some expenses do not count toward the out-of-pocket limit

The SBC excludes premiums, balance-billing charges, non-covered care, and copayments for certain services from the out-of-pocket limit. Paying those amounts therefore does not necessarily bring the member closer to the stated annual limit.

SOURCE: SBC p. 1, out-of-pocket limit exclusions.

MEDIUM | Anesthesia cost sharing differs

The surgery and hospital physician/surgeon rows show 50% coinsurance for anesthesia, while physician/surgeon services are otherwise listed at 20% in network and 40% out of network. The SBC does not explain every billing circumstance to which this separate anesthesia figure applies.

SOURCE: SBC pp. 2-3, physician/surgeon fees.

MEDIUM | Pediatric vision has network and frequency limits

Children's eye exams and glasses are listed as not covered out of network. In-network coverage is limited to one eye exam and one pair of glasses per year, respectively.

SOURCE: SBC p. 3, children's eye care.

04 Coverage items with material restrictions

Service	Network treatment	Important condition
Specialist visit	$50 in network; 40% out of network	Referral; preauthorization; potential benefit reduction
Outpatient facility	$100/day in network; 40% out of network	Preauthorization; potential benefit reduction
Hospital facility	20% in network; 40% out of network	Preauthorization; potential benefit reduction
Hospice	20% in network; 40% out of network	Preauthorization; potential benefit reduction
Specialty drugs	50% in network; 70% out of network	Drug deductible and full formulary not provided
Home health care	20% in network; 40% out of network	60 visits/year
Rehabilitation / habilitation	20% in network; 40% out of network	60 visits/year; details in SBC
Skilled nursing	20% in network; 40% out of network	60 visits/calendar year

Prior-authorization flags should be set only for the specific services for which the SBC expressly states that authorization is required. The absence of a statement in a different row does not prove that authorization is unnecessary.

SOURCE: SBC pp. 2-3, service tables.

05 Cost-sharing review

Type	Amount / rate	Applicability
Deductible	$500 individual / $1,000 family	Overall deductible
Deductible	$300	Prescription drug coverage
Deductible	$300	Occupational therapy
Out-of-pocket maximum	$2,500 / $5,000	In-network individual / family
Out-of-pocket maximum	$4,000 / $8,000	Out-of-network individual / family
Copay	$35	In-network primary care office visit
Copay	$50	In-network specialist visit
Copay	$10	In-network diagnostic test
Copay	$50	In-network CT/PET/MRI imaging
Coinsurance	40%	Out-of-network specialist and many other services
Coinsurance	70%	Out-of-network specialty drugs

Interpretation caution

The SBC states that copayment and coinsurance figures in its tables are shown after the deductible has been met, if a deductible applies. The primary care row separately states that its deductible does not apply. A listed copay alone should not be interpreted as the full amount due for all associated services.

SOURCE: SBC pp. 1-2, deductible and cost-sharing tables.

06 Possible claim payment issues

Scenario A | Specialist appointment without required approvals

Trigger: a specialist visit occurs without the referral and/or required preauthorization. The SBC says specialist coverage depends on a referral and that missing preauthorization could reduce benefits by 50% of total service cost. It does not state that every such claim is automatically denied.

Preventive action: verify the referral and authorization status before the visit; retain written confirmation.

SOURCE: SBC pp. 2, referral and specialist rows.

Scenario B | Outpatient surgery without facility preauthorization

Trigger: outpatient surgery at a facility before required preauthorization is obtained. Possible consequence: a stated reduction in benefits of up to the described 50%-of-total-cost measure; exact member liability requires clarification.

SOURCE: SBC p. 2, outpatient surgery facility fee.

Scenario C | Out-of-network lab used during in-network care

Trigger: an in-network clinician orders lab work from an out-of-network provider. Possible consequence: higher member cost sharing and potential balance billing, subject to terms not fully supplied here.

SOURCE: SBC p. 1, network warning; p. 2, diagnostic tests.

Scenario D | Rehabilitation beyond the listed visit limit

Trigger: the member reaches the 60-visit/year limit listed for rehabilitation services. The SBC identifies the limit but does not specify every consequence of exceeding it; full plan terms are needed before predicting payment.

SOURCE: SBC p. 3, rehabilitation services.

07 Further payment and coverage scenarios

Scenario E | Out-of-network pediatric eye care

Trigger: an eye exam or glasses for a child are obtained from an out-of-network provider. The SBC marks these services as "Not covered" out of network. It also limits in-network eye exams to one per year and glasses to one pair per year.

SOURCE: SBC p. 3, children's eye care.

Scenario F | Non-emergency care while outside the United States

Trigger: non-emergency treatment while traveling outside the United States. The SBC includes this category among services the plan generally does not cover. The complete policy may describe exceptions not visible in this summary.

SOURCE: SBC p. 4, excluded services.

Scenario G | Prescription spending before the separate deductible

Trigger: a member purchases covered prescription drugs before satisfying the separate $300 prescription-drug deductible. The SBC states the member pays all costs up to this specific deductible before the plan begins to pay for those services.

SOURCE: SBC p. 1, other deductibles.

Scenario H | Non-preventive service billed during a preventive visit

Trigger: services delivered during a preventive visit are classified as non-preventive. The SBC warns that the member may have to pay for services that are not preventive, even where preventive care itself is shown at no charge in network.

SOURCE: SBC p. 2, preventive care row.

08 Material unclear clauses and missing terms

1 | Full policy is not supplied

The SBC explicitly describes itself as a summary and directs the reader to the complete coverage terms. Missing full terms could change the interpretation of exclusions, network rules, procedures and limitations. Do not treat this five-page summary as a complete policy.

2 | Authorization penalty calculation

Several services refer to benefits being reduced by 50% of total service cost. The SBC does not fully explain the calculation, whether other cost sharing also applies, or how this interacts with the out-of-pocket maximum.

3 | Network status of ancillary providers

The SBC expressly warns that a network provider may use an out-of-network provider, including for lab work, but does not identify which facilities or ancillary services will be treated in network for a particular episode of care.

4 | Benefit limits after exhaustion

The SBC lists 60-visit limits for home health, rehabilitation, habilitation and skilled nursing, but does not spell out all consequences once the applicable limit has been reached or whether any exceptions exist.

5 | Appeals and claim-filing detail

The SBC mentions grievances and appeals but refers to other plan documents for complete procedures; the specific deadlines and submission requirements are not included.

SOURCE: SBC pp. 1-4; missing details are documented as unknown, not inferred.

09 Questions to ask the insurance carrier

01 Prior authorization

For specialist visits, outpatient surgery, hospital stays and hospice, exactly which approvals must be issued before care, and by whom?

02 Cost sharing

If required preauthorization is missing, how is the stated 50% benefit reduction calculated, and which resulting charges count toward the out-of-pocket limit?

03 Network

Can an in-network hospital or physician use an out-of-network laboratory or anesthesia professional, and how can I verify every participating provider before care?

04 Coverage

What happens financially when the 60-visit limit for rehabilitation or home health care is reached? Are exceptions possible?

05 Prescription drugs

How does the separate $300 prescription deductible interact with the listed tier copays and coinsurance?

06 Appeal

What are the exact claim-filing and appeal deadlines, and where are the complete written procedures?

07 Exclusion

Are there any exceptions to the exclusion for non-emergency care outside the United States?

08 Cost sharing

Which copayments are excluded from the out-of-pocket maximum, and how can I identify them before receiving care?

These questions are tied to specific statements or gaps in the supplied SBC. They are not generic recommendations to purchase or change insurance.

SOURCE: SBC pp. 1-4, corresponding benefit and rights sections.

10 Exclusions, limits and document gaps

Services listed as generally not covered

Cosmetic surgery; adult dental care; infertility treatment; long-term care; non-emergency care while traveling outside the U.S.; private-duty nursing; routine adult eye care; routine foot care. The SBC advises consulting the full policy for further exclusions.

SOURCE: SBC p. 4, excluded services.

Other services listed as covered, with possible limitations

Acupuncture when prescribed for rehabilitation purposes, bariatric surgery, chiropractic care, hearing aids and weight-loss programs. The SBC expressly states this is not a complete list and that limitations may apply.

SOURCE: SBC p. 4, other covered services.

Illustrative coverage examples are not price estimates

The SBC includes three standardized sample episodes: childbirth ($12,700 total example cost; $2,560 member example), diabetes management ($5,600; $1,820), and a simple fracture ($2,800; $1,100). These are examples printed in the SBC, not predictions of what a particular person will pay.

SOURCE: SBC p. 5, coverage examples and their stated limitations.

Unavailable information

Premium amounts; complete policy and certificate; full formulary; complete network directory; detailed authorization procedures; exact appeal deadlines; current plan validity; and the contact details represented by placeholders in this sample SBC.

11 Limitations and responsible use

What was reviewed

Only the five-page 2020-SBC-Sample.pdf supplied for this demonstration. The analysis is a manually authored example organized to mirror the FinePrintCheck report sections; it is not a run of the production AI agent.

What this report cannot establish

- Whether the sample plan is currently sold or in force.
- Whether a specific provider, facility or drug is covered for an individual.
- Whether a particular future claim will be approved, reduced or denied.
- Any terms omitted from the SBC, including exceptions in the full contract.
- Any exact financial exposure beyond the explicit amounts and conditions in the SBC.

How to use a real FinePrintCheck report

Review the highlighted provisions and page references against your actual plan documents. Ask the carrier to clarify material uncertainties in writing before relying on coverage. A report is an informational aid, not a substitute for the insurer's plan documents or an official benefit determination.

Mandatory disclaimer

This automated analysis is provided for informational purposes only and does not constitute legal, medical, financial, or insurance advice.

DEMONSTRATION ONLY: This report is based on a real sample SBC, but it is a demonstration of report presentation, not an actual FinePrintCheck agent-generated analysis. No policyholder-specific coverage was verified.

END OF SAMPLE REPORT