The Summary of Benefits and Coverage Guide

Effective September 23, 2012
As part of the Affordable Care Act (ACA), the Summary of Benefits and Coverage (SBC) Rule requires all health insurers and group health plans to provide individuals with a uniform summary of their benefits and coverage. The purpose is to give consumers an easier way to understand the coverage they already have or help them make “apples-to-apples” comparisons of available options when purchasing new coverage. The law for providing SBC Forms to applicants, subscribers, and group policyholders becomes effective on or after September 23, 2012.

This SBC Guide provides an overview of Blue Shield’s SBC Form production and distribution policy to help ensure the SBC Rule is properly carried out. To review the SBC Rule in its entirety, click here.

The SBC Rule applies to:
- Individual and Family Plans
- All group plans – fully insured and self-funded (ASO)
- Non-grandfathered plans
- Grandfathered plans and other fully insured plans not actively marketed are not required to issue SBC Forms until September 23, 2013
- Closed plans, which are not required to issue SBC Forms until September 23, 2013

Blue Shield will not provide SBC support for these plans:
- Standalone dental and vision
- Medicare Advantage
- Medicare Supplement
- Retiree Medicare Plans
- Plans Coordinating with Medicare
- Shared Advantage
- Shared Advantage Plus
The SBC Rule includes four key parts:

1. **Summary of Benefits and Coverage (SBC):**
   This uniform template describes benefits, cost sharing, and limitations. It provides consumers with an easy way to understand coverage options.

2. **Coverage examples:**
   This document will be included as part of the SBC Form. It illustrates customer costs based on a specific plan’s benefits for common medical scenarios such as having a baby or type 2 diabetes.

3. **Standard glossary:**
   This glossary from the Department of Health and Human Services (HHS) includes definitions for common medical and insurance terms used in the SBC documentation. The glossary can be found on the HHS website at: [http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf](http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf). This standard glossary link will be provided on the SBC Form.

4. **Notice of Modification:**
   The SBC Rule also requires that a Notice of Modification be sent to subscribers whenever there is a material modification to a benefit during the plan year. A material modification is any change that occurs between renewal periods which an average participant would consider an important enhancement or reduction in benefits or coverage. It is not necessary to distribute a Notice of Modification for benefit changes made in conjunction with a renewal.

   If a material change is made to a plan during the plan year that is not reflected in the most recent SBC Form, a notice must be provided to subscribers and dependents at least 60 days before the effective date of the change. In addition, an updated SBC Form needs to be sent within 60 days of the Notice of Modification being distributed.
Key dates for initial SBC Rule rollout

The SBC Rule has two different effective dates, depending on whether the enrollee is enrolling for the first time or re-enrolling during the group’s open enrollment period.

**For renewing subscribers**
The SBC Rule is effective on the first day of the first open enrollment period beginning on or after September 23, 2012. The rule applies on the date that the open enrollment period begins on or after September 23, 2012, not when the plan year effective date starts.

**For new hires and special enrollees**
For newly eligible individuals and special enrollees, the SBC Rule is effective on the first day of the first plan year that starts on or after September 23, 2012.

<table>
<thead>
<tr>
<th>SBC Forms need to be distributed when...</th>
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<th>SBC Forms need to be distributed starting...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upon request</td>
<td>Within 7 business days of subscriber/shopper request.</td>
<td>Upon request after 9/23/12.</td>
</tr>
<tr>
<td>Upon application</td>
<td>Within 7 business days of receiving a substantially completed application.</td>
<td>Upon application receipt after 9/23/12.</td>
</tr>
<tr>
<td>Upon acceptance of coverage</td>
<td>By first day of coverage, only if information has changed from a prior issued SBC Form, or no prior SBC Form was distributed.</td>
<td>After 9/23/12.</td>
</tr>
<tr>
<td>Upon renewal/reissue</td>
<td>30 days prior to effective date.</td>
<td>Upon first renewal after 9/23/12.</td>
</tr>
</tbody>
</table>
### When SBC Forms are required for group plans

<table>
<thead>
<tr>
<th>Group Plans</th>
<th>SBC Forms need to be distributed when...</th>
<th>SBC Forms to be distributed...</th>
<th>SBC Forms need to be distributed starting...</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Upon request</td>
<td>Within 7 business days of subscriber’s request.</td>
<td>On or after first day of plan year following 9/23/12.</td>
<td>Next plan year begins 1/1/2013. If subscriber requests an SBC Form on 9/24/2012, then an SBC Form is not required.</td>
</tr>
<tr>
<td></td>
<td>Open enrollment</td>
<td>By the first day when subscriber is eligible to enroll.</td>
<td>First day of open enrollment on or after 9/23/12; does not apply if first day of open enrollment begins before 9/23/12.</td>
<td>Open enrollment begins 9/17/12 -10/1/12; plan year begins 1/1/2013. SBC not required for 9/17 open enrollment. SBC will be provided on first day of coverage: 1/1/2013 (see “Upon coverage” below).</td>
</tr>
<tr>
<td></td>
<td>Upon coverage</td>
<td>By the first day of coverage, only if the information changed from a prior issued SBC Form, or no enrollment SBC Form was distributed.</td>
<td>First day of plan year following 9/23/12.</td>
<td>Open enrollment begins 9/17/12 -10/1/12. Plan year begins 1/1/2013. SBC will be provided on first day of coverage: 1/1/2013.</td>
</tr>
<tr>
<td></td>
<td>Special enrollment</td>
<td>Within 90 days of special enrollment event.</td>
<td>First special enrollment event in the first plan year following 9/23/12.</td>
<td>New hire joins group 9/24/2012; plan year begins 1/1/2013. SBC not required.</td>
</tr>
<tr>
<td></td>
<td>Upon renewal/reissue</td>
<td>30 days prior to effective date. If the benefits with the group are not finalized 30 days before the effective date, SBC Forms need to be distributed no later than 7 business days after the policy/plan is issued or written notice of purchase decision (including confirmation of benefits purchased) is sent to Blue Shield, whichever occurs first.</td>
<td>30 days prior to effective date of first renewal following 9/23/12. If renewal decision is late, SBC Forms need to be sent within 7 business days of the date the policy/plan is issued or written notice of a purchase decision is sent to Blue Shield, whichever occurs first.</td>
<td>Group with 10/1/12 effective renewal; SBC not required for renewal, since 30 days prior is before 9/23. To be included in materials for next renewal.</td>
</tr>
</tbody>
</table>
Translation requirements
The SBC forms must be provided **upon request** in different languages if 10 percent of the population in the area speak those languages. Blue Shield will be offering the SBC Forms **upon member level request** in Spanish, Chinese, Tagalog, and Navajo. Instructions on how to request translated SBC Forms and contact numbers will be on the SBC Forms.

Blue Shield **will not** be providing language translation for self-funded (ASO) clients by default. If a self-funded (ASO) client has specific translation needs, they should contact their Blue Shield account manager.

How to access SBC Forms
Upon completion, SBC Forms can be accessed electronically at:

- **SBC Customer Center**: This site provides fully funded Blue Shield policyholders with access to SBC Forms that have been customized to match their specific group plans. This link can be found at www.bscadocs.com/sbc.

- **Blue Shield website**: This site provides SBC Forms for Blue Shield portfolio individual and family medical plans and portfolio small, midsize, and large group medical plans.

External vendors (e.g., pharmacy, mental health)
**Fully insured groups**: If a group uses external, non-Blue Shield vendors for benefit services for pharmacy or mental health services, Blue Shield **cannot** provide external vendor information within its SBC Forms – any fields that pertain to external vendors will say “not covered.” The group is responsible for obtaining and distributing a separate SBC Form for the additional benefits.

**Self-funded (ASO) groups**: If a self-funded (ASO) client uses external vendors for any benefit services (e.g., pharmacy, mental health), the self-funded (ASO) client is responsible for obtaining the external vendor information and including it in the SBC Form provided by Blue Shield. We will ask for a copy of the finalized SBC Forms if available.
Penalties and fines
The failure to deliver SBC Forms to subscribers within the required time frame may result in a fine of $1,000 per each covered individual. An additional fine of $100 per day per person may be imposed until the SBC Forms are issued.

Note: The group administrator is responsible for distributing SBC Forms to plan participants. Failure to comply may result in a group policyholder being fined.

Our obligations
• **Fully insured**: By law, both group policyholders and the carrier have a joint obligation to create and distribute the SBC Form to enrollees. By contract, Blue Shield will produce the SBC Forms and provide them to the group policyholders, and the group will in turn be required to issue the SBC Forms to their enrollees.
• **Self-funded (ASO)**: The obligation to create and distribute SBC Forms to enrollees rests entirely on the self-funded (ASO) group policyholder.

Group contract changes
Starting October 1, 2012, Blue Shield will modify group agreements to clarify obligations under the SBC Rule.
• **New group contracts** will include SBC language upon signing, starting October 1, 2012.
• **Renewing group contracts** will be updated on a rolling basis based on renewal date, which means starting October 1, 2012, SBC language will be included when the group renews. Their existing contract will remain in place until then.

Attestation
Blue Shield will require fully funded group policyholders to attest via the SBC Customer Center to the receipt of the SBC Forms and acknowledge that they are responsible for the distribution of these forms to their subscribers.
Fully Insured Group: Overview

By law, Blue Shield and group policyholders are jointly responsible for meeting the SBC requirements for creation and delivery of the SBC Forms to subscribers.

By contract, Blue Shield responsibilities include:
- Creating SBC Forms for group plans according to the SBC Rule
- Delivering SBC Forms to group policyholders via the Blue Shield website and online SBC Customer Center
- Providing SBC Forms to group subscribers upon request
- Updating SBC Forms when changes occur and providing notification when the modified version is available

By contract, group policyholders are responsible for ensuring that SBC Forms are distributed to subscribers and dependents in a manner that complies with the SBC Rule.

The required SBC Forms will not replace existing Blue Shield documents such as benefit summaries, benefit matrices, and Evidence of Coverage, which are governed by separate regulations. Instead, it will be provided alongside them where appropriate, as an additional summary to help subscribers compare plans and health insurers using the same standard criteria.

SBC Forms must be provided to prospective, new, and renewing subscribers on an ongoing basis at the following times:

<table>
<thead>
<tr>
<th>Trigger event</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upon request</td>
<td>Within 7 business days of subscriber’s request.</td>
</tr>
<tr>
<td>Open enrollment</td>
<td>By the first day when subscriber is eligible to enroll.</td>
</tr>
<tr>
<td>Upon coverage</td>
<td>By the first day of coverage, only if the information changed from a prior issued SBC Form, or no enrollment SBC Form was distributed.</td>
</tr>
<tr>
<td>Special enrollment</td>
<td>Within 90 days of special enrollment event.</td>
</tr>
<tr>
<td>Upon renewal/reissue</td>
<td>30 days prior to effective date.</td>
</tr>
</tbody>
</table>

If the benefits with the group are not finalized 30 days before the effective date, SBC Forms need to be distributed no later than 7 business days after the policy/plan is issued or written notice of purchase decision (including confirmation of benefits purchased) is sent to Blue Shield, whichever occurs first.
Renewal information

It is important that Blue Shield receives group finalized renewal information as early as possible so updated SBC Forms can be created and distributed. Blue Shield sales representatives will work with groups on renewal benefits. The number of plans offered will determine how quickly final SBC Forms can be produced once the benefits have been finalized.

Subscribers must receive finalized SBC Forms with the rest of their open enrollment materials no later than the first day of the open enrollment period. (SBC Forms are required only if the open enrollment period begins on or after September 23, 2012.)

Notice of Modification

In addition to the SBC form, the SBC Rule also requires that a Notice of Modification be sent to subscribers whenever there is a material modification to a benefit during the plan year. A material modification is any change that occurs between renewal periods which an average participant would consider an important enhancement or reduction in benefits or coverage. It is not necessary to distribute a Notice of Modification for benefit changes made in conjunction with a renewal.

If a material change is made to a plan during the plan year that is not reflected in the most recent SBC Form, a notice must be provided to subscribers and dependents at least 60 days before the effective date of the change. In addition, an updated SBC Form needs to be sent within 60 days of the Notice of Modification being distributed.

Blue Shield will work with group policyholders who may need to issue a Notice of Modification to subscribers.
Fully Insured: Small Group

Small groups (2-50 eligible employees)

During the initial rollout of this new requirement, Blue Shield will create and distribute SBC Forms via mail to small group subscribers and dependents upon enrollment, renewal, qualifying events, and request. Additionally, Blue Shield will provide employer groups electronic access to its SBC Forms.

Blue Shield is committed to providing:

- **Standard SBC Forms for Blue Shield’s portfolio plans** prior to plan selection and finalization as part of the application process. These standard portfolio forms are available via the Blue Shield website.

- **Customized SBC Forms** once benefit selections have been made and finalized. Groups will have access to SBC Forms for the specific plans they purchase for distribution to subscribers and dependents.

How to access Blue Shield SBC Forms

SBC Forms can be accessed electronically at:

- **Summary of Benefits and Coverage Customer Center**: This site provides Blue Shield’s fully funded group policyholders with access to SBC Forms that have been customized to match their specific group plans. The group contact simply needs to enter their customer ID number, and attest to receiving the SBC Forms.

  Blue Shield will notify group contacts when new/updated forms have been posted to the Blue Shield SBC Customer Center.

- **Blue Shield website**: This site provides SBC Forms for Blue Shield portfolio individual and family medical plans and portfolio small, midsize, and large group medical plans.

Visit these websites September 23, 2012!

Questions?

For answers to Blue Shield SBC inquiries for small groups, please contact your account sales representative or broker. Group policyholders can refer employees to the customer service number on the back of their Blue Shield member ID card.

- **Employer Services**: (800) 325-5166
- **Producer Services**: (800) 559-5905
- **SBC Customer Center**: sbc_ops@blueshieldca.com or (800) 325-5166
Fully insured midsize and large groups and Premier Accounts (51+ eligible employees)

Blue Shield is responsible for the creation and distribution of electronic copies of the SBC Forms to fully insured midsize and large groups, and Premier Accounts (51+ eligible employees). These clients are then responsible for downloading, printing, and/or electronically distributing the documentation to subscribers and their dependents in a manner that complies with the SBC Rule. To review SBC Rule distribution requirements, visit: [www.dol.gov/ebsa/healthreform/](http://www.dol.gov/ebsa/healthreform/).

Blue Shield will provide:

- **Standard SBC Forms for Blue Shield's portfolio plans** prior to plan selection and finalization as part of the application process. These PDF formatted SBC Forms can be accessed via the Blue Shield website.

- **Customized SBC Forms** once benefit selections have been made and finalized. Blue Shield will provide fully insured groups with customized PDF formatted SBC Forms for the plans they purchased. Fully funded groups are responsible for distributing these forms to their subscribers and dependents.

**How to access SBC Forms**

Upon completion, SBC Forms can be accessed electronically at:

- **SBC Customer Center**: This site provides fully funded Blue Shield policyholders with access to SBC Forms that have been customized to match their specific group plans. The group contact simply needs to enter their customer ID number, attest to receiving the SBC Forms, and download them for distribution to subscribers and dependents.

  Blue Shield will notify group contacts, letting them know when new/updated forms have been posted to the Blue Shield SBC Customer Center.

- **Blue Shield website**: This site provides SBC Forms for Blue Shield portfolio individual and family medical plans and portfolio small, midsize, and large group medical plans.

**Questions?**

For answers to Blue Shield SBC inquiries, please contact your account sales representative or producer/consultant. Group policyholders can refer employees to the customer service number on the back of their Blue Shield ID card.

- **Midsize and large group SBC Customer Center**: sbc_ops@blueshieldca.com or 800-837-4215.

- **Premier Accounts SBC Customer Center**: sbc_ops@blueshieldca.com or (888) 866-5751.
Welcome Acme Anvil Corporation and thank you for choosing Blue Shield of California. You can access your documents by visiting the SBC Customer Center at www.bscadocs.com/sbc and then entering your customer number to log in. Your customer number is 1234567.

Blue Shield requires group contacts to provide an electronic signature to confirm receipt of the SBC Forms and their intent to distribute them to their subscribers and dependents. The group contact will receive an email confirmation of their attestation from Blue Shield to keep on file.

To confirm your receipt of the SBC Forms and your intent to distribute them to your subscribers and dependents your digital signature is required. You will receive a confirmation email from us for your files.

Company name: Acme Anvil Corporation  
Primary contact: Harry Winston  
Customer #: 91974411  
Contact email: harry@acmecorp.com

confirm receipt of materials & intent to distribute

To confirm your receipt of the SBC Forms and your intent to distribute them to your subscribers and dependents your digital signature is required. You will receive a confirmation email from us for your files.

Company name: Acme Anvil Corporation  
Primary contact: Harry Winston  
Customer #: 91974411  
Contact email: harry@acmecorp.com

click here to confirm that Blue Shield of California has provided Summary of Benefits and Coverage Forms for distribution to all subscribers and dependents subscribing to coverage from Blue Shield of California.

Electronic signature: 

first name: 

last name: 

Confirm

Questions?  
sbc_ops@blueshieldca.com

Step 1 : notification

Blue Shield will notify group contacts when new/updated SBC Forms are posted on the Blue Shield SBC Customer Center.

Step 2 : online access

Group contacts can access their customized Blue Shield SBC Forms online via The SBC Customer Center located at www.bscadocs.com/sbc by simply entering in their customer number.

Step 3 : e-signature

Blue Shield requires group contacts to provide an electronic signature to confirm receipt of the SBC Forms and their intent to distribute them to their subscribers and dependents. The group contact will receive an email confirmation of their attestation from Blue Shield to keep on file.

Step 4 : download

Once a group attests to the receipt of their SBC Forms, they can download the PDFs and distribute them, as per the SBC Rule, to their subscribers and dependents.

Download your group’s SBC Forms and distribute them to your subscribers and dependents.

Download documents

- Access Blue HMO Plan.60.65.69.70.71.72 (8.3mb .pdf)
- Blue Spectrum PPO 250.80.90.99.100.101.101.101 (8.7mb .pdf)
Self-funded (ASO) group overview

How Blue Shield will distribute SBC Form to self-funded (ASO) midsize and large groups and Premier Accounts clients. Blue Shield has no legal obligation to create or distribute the SBC Form for self-funded (ASO) clients. As a courtesy, Blue Shield will assume responsibility for creating and providing electronic copies of the SBC Forms to self-funded (ASO) clients, except for Shared Advantage and Shared Advantage Plus groups. Self-funded (ASO) clients are then responsible for downloading, printing, modifying as needed (e.g., external vendors) and distributing their SBC Forms to subscribers and their dependents in a manner that complies with the requirements of the regulation.

To review SBC Rule distribution requirements, visit www.dol.gov/ebsa/healthreform/.

Self-funded (ASO) client responsibilities:
• Self-funded (ASO) clients have sole responsibility for the SBC Forms once they are delivered from Blue Shield. By law, Blue Shield is not responsible for accuracy or content.
• Self-funded (ASO) clients are responsible (by SBC Rule and Blue Shield contract) for distributing SBC Forms to prospective, new, and renewing subscribers according to the federal regulation. SBC Forms must be provided on an ongoing basis at the following times:

<table>
<thead>
<tr>
<th>Trigger event</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upon request</td>
<td>Within 7 business days of subscriber’s request.</td>
</tr>
<tr>
<td>Open enrollment</td>
<td>By the first day when subscriber is eligible to enroll.</td>
</tr>
<tr>
<td>Upon coverage</td>
<td>By the first day of coverage, only if the information changed from a prior issued SBC, or no enrollment SBC was distributed.</td>
</tr>
<tr>
<td>Special enrollment</td>
<td>Within 90 days of special enrollment event.</td>
</tr>
<tr>
<td>Upon renewal/reissue</td>
<td>30 days prior to effective date. If the benefits with the group are not finalized 30 days before the effective date, SBC Forms need to be distributed no later than 7 business days after the policy/plan is issued or written notice of purchase decision (including confirmation of benefits purchased) is sent to Blue Shield, whichever occurs first.</td>
</tr>
</tbody>
</table>

External vendors (e.g., pharmacy, specialty benefits)
If a self-funded (ASO) client uses external vendors for any benefit services (e.g., pharmacy, mental health) the self-funded (ASO) client is responsible for obtaining the external vendor information and including it in the SBC Form provided by Blue Shield. Blue Shield will ask for a copy of the finalized SBC Forms if available.
Language translation
Blue Shield will not be providing language translation for self-funded (ASO) by default. If an ASO client has specific translation needs, they should contact their Blue Shield account manager.

Renewal information
It is important that Blue Shield receives group renewal information as early as possible so updated SBC Forms can be created and distributed. Blue Shield sales representatives will work with groups on renewal benefits. The number of plans offered will determine how quickly final SBC Forms can be produced once the benefits have been finalized.

How self-funded (ASO) clients will receive their SBC Forms from Blue Shield
For new and renewing self-funded (ASO) clients: Upon benefit finalization, Blue Shield account managers will email SBC Forms to the self-funded (ASO) clients, so they can distribute to their subscribers. SBC Forms will be provided in a Word document format, so self-funded (ASO) client can modify as necessary. Once the SBC Forms have been delivered, they are considered the property of the self-funded (ASO) client and Blue Shield cannot be held responsible for the content or accuracy of the information.

Notice of Modification
In addition to the SBC Form, the SBC Rule also requires that a Notice of Modification be sent to subscribers whenever there is a material modification to a benefit during the plan year. A material modification is any change that occurs between renewal periods which an average participant would consider an important enhancement or reduction in benefits or coverage. It is not necessary to distribute a Notice of Modification for benefit changes made in conjunction with a renewal.

If a material change is made to a plan during the plan year that is not reflected in the most recent SBC Form, a notice must be provided to subscribers and dependents at least 60 days before the effective date of the change. In addition, an updated SBC Form needs to be sent within 60 days of the Notice of Modification being distributed. Blue Shield will work with self-funded (ASO) clients who are solely responsible for issuing a Notice of Modification to subscribers.

Questions?
For answers to Blue Shield SBC inquiries, please contact your account sales representative or producer/consultant.
Blue Shield will create and make available/distribute SBC Forms to all Individual and Family Plan (IFP) shoppers, new enrollees, and policyholders.

**How will Blue Shield distribute SBC Forms to Individual and Family Plan customers?**

Blue Shield will distribute SBC Forms to Individual and Family Plan customers online at blueshieldca.com/sbc beginning September 23, 2012. Also, Blue Shield will provide printed SBC Forms to IFP customers upon request when they contact Blue Shield Customer Service. Blue Shield will update materials, as needed, to provide customers with information on where to get SBC Forms.

The required SBC Forms will not replace existing Blue Shield documents such as benefit summaries, benefit matrices, and Evidence of Coverage, which are governed by separate regulations. Instead, it will be provided alongside them where appropriate, as an additional summary to help subscribers compare plans and health insurers using the same standard criteria.

**SBC Forms will be provided on an ongoing basis at the following times for Individual and Family Plans**

<table>
<thead>
<tr>
<th>Trigger event</th>
<th>Terms</th>
<th>How Blue Shield will support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upon request</td>
<td>Within 7 business days of subscriber/shopper request.</td>
<td>If a customer calls Blue Shield or their broker to request an SBC Form, one will be provided within the required time frame.</td>
</tr>
<tr>
<td>Upon application</td>
<td>Within 7 business days of receiving a substantially completed application.</td>
<td>SBC Forms will be available for IFP applicants via the Blue Shield website. Instructions on how to access them will also be included on the paper application.</td>
</tr>
<tr>
<td>Upon acceptance of coverage</td>
<td>By first day of coverage, only if information has changed from a prior issued SBC, or no prior SBC distributed.</td>
<td>New subscribers will receive instructions on how to access SBC Forms in their welcome packet.</td>
</tr>
<tr>
<td>Upon renewal/reissue</td>
<td>30 days prior to effective date.</td>
<td>Renewing/reissuing subscribers will receive instructions on how to access SBC Forms in their renewal packet.</td>
</tr>
</tbody>
</table>
What is in an SBC Form?

- **Summary of Benefits and Coverage (SBC):** This uniform template describes benefits, cost sharing, and limitations. It provides consumers with an easy way to understand coverage options.

- **Coverage examples:** This document will be included as part of the SBC Form. It illustrates customer costs based on a specific plan’s benefits for common medical scenarios such as having a baby or type 2 diabetes.

- **Standard glossary:** This glossary from the Department of Health and Human Services (HHS) includes definitions for common medical and insurance terms used in the SBC documentation. The glossary can be found on the HHS website at: [http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf](http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf). This standard glossary link will be provided on the SBC Form.

What is a Notice of Modification?

In addition to the SBC Form, the SBC Rule also requires that a Notice of Modification be sent to subscribers whenever there is a material modification to a benefit during the plan year. A material modification is any change that occurs **between renewal periods** which an average participant would consider an important enhancement or reduction in benefits or coverage. It is not necessary to distribute a Notice of Modification for benefit changes made in conjunction with a renewal.

If a material change is made to a plan during the plan year that is not reflected in the most recent SBC Form, a notice must be provided to subscribers and dependents at least 60 days before the effective date of the change. In addition, an updated SBC Form needs to be sent within 60 days of the Notice of Modification being distributed.

What are the effective dates related to SBC Forms?

For open enrollment: The SBC Rule is effective on the first day of the first annual enrollment period beginning on and after September 23, 2012. The rule applies on the date that the annual enrollment period begins after September 23, 2012, not the date the plan year starts.

Other than open enrollment: For newly eligible individuals and special enrollees, the SBC Rule is effective for an enrollment on or after the first day of the plan year that starts on or after September 23, 2012.

Will Blue Shield be in compliance with the SBC Rule by September 23, 2012?

Yes, we’re on track to be compliant by the effective date of September 23, 2012.
Are there penalties and/or fines for not being in compliance?
Yes, failure to deliver an SBC Form to subscribers within the required time frame may result in a fine of $1,000 per each covered individual. Additionally, a fine of $100 per day per person may be imposed until the SBC Forms are issued.

By law, must an SBC Form be provided to employees?
Yes, the Affordable Care Act (ACA) requires that an SBC Form be provided to all groups and individual subscribers at specific times.

How will special enrollments be handled?
Special enrollment pertains to eligibility changes due to death, marriage, birth of a dependent, etc. The SBC must be sent within 90 days after enrollment. The SBC Rule for special enrollees applies beginning on the first day of the first plan year beginning on or after September 23, 2013.

Must SBC Forms be provided to individuals who are COBRA qualified beneficiaries?
Yes, a COBRA beneficiary must get an SBC Form at the same time and in the same manner as active employees.

How will Blue Shield support the preparation and distribution of SBC Forms for fully insured groups?
Blue Shield will prepare and distribute PDF formatted SBC Forms to the group administrator. For small groups (2-50 eligible employees), during this initial rollout of this new requirement, Blue Shield will distribute the SBC Forms to the group subscribers and dependents. For midsize and large groups (51+), Blue Shield will provide access to the SBC Forms via the online Blue Shield SBC Customer Center.

How will Blue Shield support the preparation and distribution of SBC Forms for self-funded (ASO) groups?
Blue Shield has no legal obligation to create or distribute the SBC Forms for self-funded (ASO) clients. As a courtesy, Blue Shield will assume responsibility for creating and providing electronic copies of the SBC Forms to self-funded (ASO) clients, except for Shared Advantage and Shared Advantage Plus accounts. Self-funded (ASO) clients are then responsible for downloading, printing, modifying as needed (e.g., external vendors) and distributing that documentation to subscribers and their dependents in a manner that complies with the SBC Rule. Self-funded (ASO) clients have sole responsibility for the SBC Forms once they are delivered from Blue Shield. By law, Blue Shield is not responsible for accuracy, content, or SBC Rule compliance.

Can a self-funded (ASO) client prepare their own SBC Forms? If so, will they be required to sign a form indicating this?
Yes, however, we will need documentation in writing that the ASO group will be producing their own SBC Forms.
How will Blue Shield provide the SBC Forms?  
Blue Shield will provide access to SBC Forms electronically the following ways:

- **Blue Shield website**: Find standard SBC Forms for Individual and Family Plans, small, midsize, and large group plans.
- **SBC Customer Center**: Blue Shield policyholders for fully funded small, midsize, and large groups can access their customized SBC Forms here.
- **Self-funded (ASO) clients**: For new and renewing self-funded (ASO) clients, Blue Shield account managers will email SBC Forms, upon benefit finalization, to the self-funded (ASO) clients so they can distribute to their subscribers. SBC Forms will be provided in a Word document format so self-funded (ASO) clients can modify as necessary. Once the SBC Forms have been delivered, they are considered the property of the self-funded (ASO) clients and Blue Shield cannot be held responsible for the content or accuracy of the information.

Are Summary of Benefit and Coverage Forms and Benefit Summaries the same?  
No. Summary of Benefit and Coverage Forms (SBCs) are uniform templates that provide high-level overviews of coverage benefits. The purpose is to provide consumers and customers with “apples-to-apples” comparisons of benefits when making coverage decisions. Benefit summaries are detailed descriptions of a plan’s benefits. Benefit summaries continue to be available for Blue Shield plans and should be used to fully understand a plan’s coverage and benefits.

Will Blue Shield support providing information for external vendors such as pharmacy or specialty benefits?  
**Fully insured groups**: If a group uses external, non-Blue Shield vendors for benefit services for pharmacy or mental health services, Blue Shield cannot provide external vendor information within its SBC Forms – any fields that pertain to external vendors will say “not covered.” The group is responsible for obtaining and distributing a separate SBC Form for the additional benefits.

**Self-funded (ASO) clients**: If a self-funded (ASO) client uses external vendors for any benefit services (e.g., pharmacy, mental health), the self-funded (ASO) client is responsible for obtaining the external vendor information and including it in the SBC Form provided by Blue Shield. Blue Shield will ask for a copy of the finalized SBC Forms if available.

Will Blue Shield translate the SBC Forms?  
Yes, but only for fully insured accounts. The SBC Rule requires that the SBC Forms be provided upon member level request in different languages if 10 percent of the population in the area speaks those languages. Blue Shield will be offering the SBC Forms upon member level request in Spanish, Chinese, Tagalog, and Navajo. Instructions on how to request translated language and contact numbers will be provided on the SBC Forms.

Blue Shield will not be providing language translation for self-funded (ASO) clients by default. If a self-funded (ASO) client has specific translation needs, they should contact their Blue Shield account manager.
Frequently Asked Questions

Must premium information be included in the SBC Forms?
No, this requirement was removed in the guidance issued February 9, 2012.

What if a state already has standards for benefit summaries?
The federal standards will override any state standards that call for less information. But any state mandates that go above and beyond the federal standards will continue to apply. In California, carriers may be required to issue separate benefit summaries and SBC Forms.

When do SBC Forms need to be provided?
The SBC Forms will need to be provided as follows:

- **Upon request**: Within seven business days of subscriber/shopper request.
- **Upon application**: Within seven business days of receiving a substantially complete application.
- **Upon acceptance of coverage**: By first day of coverage, only if information has changed from a prior issued SBC Form, or no prior SBC Form was distributed.
- **Upon renewal/reissue**: 30 days prior to the effective date. If benefits are not finalized 30 days before the effective date, SBC Forms need to be distributed no later than seven business days after the policy/plan is issued or written notice of purchase decision (including confirmation of benefits purchased) is sent to Blue Shield, whichever occurs first.

Can SBC Forms be combined with other materials?
For groups, the SBC Forms can be combined with other materials (such as the summary plan description) only if the SBC Forms are in the front of the document. For individual policies, the SBC Forms must be provided as a standalone document, but it can be included in the same mailing with other documents.

Which SBC Forms need to be distributed to group enrollees at the time of initial enrollment as well as on renewal?
As part of the initial enrollment materials, separate SBC Forms must be provided for each benefit package that the participants/beneficiaries are eligible for. At renewal, subscribers and dependents must initially receive only the SBC Forms related to the plan in which they are enrolled. If participants request an SBC Form for a plan they are not currently enrolled in, but for which they are eligible, the plan or issuer must provide them that SBC Form within seven business days of the request.

What are the requirements for providing an SBC Form to a dependent in a group?
An SBC Form must be sent to the last known address of the dependent.
### Overview

### Conditions

**Fully Insured Group**
- Overview
- Small Group
- Large Group/Premier Accounts
- SBC Customer Center Steps

### Self-Funded (ASO) Groups

### Individual and Family Plans

### Frequently Asked Questions

### SBC Form Sample

### Resources

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**Blue Shield of California: Shield Spectrum PPO 500 90/70**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

---

**Overview**

**Conditions**

- **Fully Insured Group**
  - Overview
  - Small Group
  - Large Group/Premier Accounts
  - SBC Customer Center Steps

- **Self-Funded (ASO) Groups**

- **Individual and Family Plans**

- **Frequently Asked Questions**

- **SBC Form Sample**

- **Resources**

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**Important Questions**

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<tr>
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<td>$500 person / $1,000 2-persons / $1,500 family Preventive services and some office visits are not subject to the deductible.</td>
<td>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For preferred providers $2,000 person / $4,000 2-persons / $6,000 family For non-preferred providers $5,000 person / $10,000 2-persons / $15,000 family</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
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<td>Yes. For a list of preferred providers, see <a href="http://www.blueshieldca.com">www.blueshieldca.com</a> or call 1-800-424-6521.</td>
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---

**SBC Form Sample**

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period:** 7/1/2012-6/30/2013

**Coverage for:** Family | Plan Type: PPO

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**SBC Form Sample**

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period:** 7/1/2012-6/30/2013

**Coverage for:** Family | Plan Type: PPO

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<th>Services You May Need</th>
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<th>Your Cost If You Use a Non-Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$15/visit</td>
<td>30% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$15/visit</td>
<td>30% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$25/visit</td>
<td>50% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td>If you have a test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$15/visit</td>
<td>30% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% co-insurance</td>
<td>30% co-insurance</td>
<td>Prior authorization is required. Failure to obtain prior authorization may result in an additional penalty or non-payment.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td>none</td>
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<td>Specialty drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% <strong>co-insurance</strong></td>
<td>30% <strong>co-insurance</strong></td>
<td>Prior authorization is required. Failure to obtain prior authorization may result in an additional penalty or non-payment. The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $350 per day. Members are responsible for 30% of this $350 per day, plus all charges in excess of $350.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% <strong>co-insurance</strong></td>
<td>30% <strong>co-insurance</strong></td>
<td>none</td>
</tr>
<tr>
<td>Emergency room services</td>
<td>$100/ visit + 10% <strong>co-insurance</strong></td>
<td>$100/ visit + 10% <strong>co-insurance</strong></td>
<td><strong>Copayment</strong> does not apply if the member is directly admitted to the hospital.</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>10% <strong>co-insurance</strong></td>
<td>10% <strong>co-insurance</strong></td>
<td>none</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$15/visit</td>
<td>30% <strong>co-insurance</strong></td>
<td>none</td>
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### Blue Shield of California: Shield Spectrum PPO 500 90/70

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

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<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% co-insurance</td>
<td>30% co-insurance</td>
<td>Prior authorization is required. Failure to obtain prior authorization may result in an additional penalty or non-payment. The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 30% of this $600 per day, plus all charges in excess of $600.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Physician/surgeon fee</td>
<td>10% co-insurance</td>
<td>30% co-insurance</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$15/visit</td>
<td>30% co-insurance</td>
<td>The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 30% of this $600 per day, plus all charges in excess of $600.</td>
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<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health inpatient services</td>
<td>10% co-insurance</td>
<td>30% co-insurance</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Substance use disorder outpatient services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Substance use disorder inpatient services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>10% co-insurance</td>
<td>30% co-insurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Delivery and all inpatient services</td>
<td>10% co-insurance</td>
<td>30% co-insurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% co-insurance</td>
<td>Not covered</td>
<td>Up to 100 prior authorized visits per Calendar Year. Prior authorization is required. Failure to obtain prior authorization may result in an additional penalty or non-payment.</td>
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### Blue Shield of California: Shield Spectrum PPO 500 90/70

**Coverage Period:** 7/1/2012-6/30/2013  
**Coverage for:** Family | **Plan Type:** PPO

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<td>Rehabilitation services</td>
<td>$15/visit</td>
<td>50% co-insurance</td>
<td>Up to 100 prior authorized visits per Calendar Year. Prior authorization is required. Failure to obtain prior authorization may result in an additional penalty or non-payment.</td>
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<tr>
<td>Habilitation services</td>
<td>$15/visit</td>
<td>50% co-insurance</td>
<td></td>
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<tr>
<td>Skilled nursing care</td>
<td>10% co-insurance</td>
<td>10% co-insurance</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% co-insurance</td>
<td>30% co-insurance</td>
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<tr>
<td>Hospice service</td>
<td>No charge</td>
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#### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Infertility treatment
- Private-duty nursing
- Weight loss programs
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Services that are not medically necessary.
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine foot care

**Questions:** Call 1-800-424-6521 or visit us at www.blueshieldca.com. 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.cciio.cms.gov or call 1-866-444-3272 to request a copy.
Blue Shield of California: Shield Spectrum PPO 500 90/70

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-424-6521. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 1-800-424-6521. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care at (888) 466-2219.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al (866) 346-7198.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (866) 346-7198.]
[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (866) 346-7198.]
[Navajo (Dine): Dinek’ehgo shika a’ohwoł ninisíingo, kwiiijgo holné’ (866) 346-7198.]

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

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### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

#### Having a baby
(normal delivery)

<table>
<thead>
<tr>
<th>Sample care costs:</th>
<th>Amount owed to providers: $7,540</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient pays:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copays</td>
<td>$190</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$630</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$170</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,490</strong></td>
</tr>
</tbody>
</table>

#### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

<table>
<thead>
<tr>
<th>Sample care costs:</th>
<th>Amount owed to providers: $5,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient pays:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copays</td>
<td>$130</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$130</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$2,930</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$3,690</strong></td>
</tr>
</tbody>
</table>

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Blue Shield of California: Shield Spectrum PPO 500 90/70  
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Questions and answers about the 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 by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
• The patient’s condition was not an excluded or preexisting condition.
• All services and treatments started and ended in the same coverage 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, copayments, and coinsurance 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 this condition 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 Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in 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 copayments, deductibles, and coinsurance. You should also 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.

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For current information on the SBC Rule, visit these useful websites:

- The Department of Labor's SBC Rule
- Health and Human Services Uniform Glossary
- The Department of Labor's Disclosure Requirements
- Blue Shield Public Website: SBC Webpage
- Blue Shield SBC Customer Center