BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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October 20, 2011

The Honorable Timothy Geithner
Secretary
U.S. Department of the Treasury
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

The Honorable Hilda Solis
Secretary
U.S. Department of Labor
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington DC 20201

ATTENTION: (Treasury), RIN 1210–AB52 (Room N-5653) (Labor), and CMS–9982–P (P.O. Box 8016) (HHS)

Dear Secretaries Geithner, Solis and Sebelius:

The Blue Cross and Blue Shield Association ("BCBSA") is pleased to submit comments to the:

(1) Centers for Medicare and Medicaid Services, Department of Health and Human Services, Notice of Proposed Rulemaking ("NPRM") – Summary of Benefits and Coverage and the Uniform Glossary. 76 Fed. Reg. 52442 (Aug. 22, 2011); and

(2) Centers for Medicare and Medicaid Services, Department of Health and Human Services, Solicitation of Comments – Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials Under the Public Health Service Act. 76 Fed. Reg. 52475 (Aug. 22, 2011).

BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that provide coverage to approximately 100 million Americans. Plans provide health care options in all 50 states, the District of Columbia and Puerto Rico, in the individual, small and large group markets, including those who self-insure. BCBSA also participates in the Federal Employees Health Benefits Program ("FEHB program") and other government programs. The NPRM and Solicitation of Comments affect almost all members in our commercial lines of business and also millions of Federal employees and their dependents who participate in BCBS options under the FEHB program.

Background: Section 2715 of the Public Health Service Act ("PHSA")

The NPRM and the companion Solicitation of Comments propose standards for implementing Public Health Services Act (“ PHSA”) Section 2715, as adopted by the Affordable Care Act ("ACA"). PHSA Section 2715 directs the Secretary to develop a summary of benefits and coverage ("SBC") explanation to assist individuals with understanding their health insurance coverage.

Section 2715 of the PHSA requires the Secretary to develop these standards not later than 12 months after the date of enactment of the ACA, (March 23, 2011), and that insurers shall deliver SBCs not later than 24 months after the enactment of the ACA (March 23, 2012). Importantly, the NPRM was not issued until August 22, 2011 and the final rule will not be issued until at least the end of this year, nine months behind schedule. However, the NRPM maintains March 23, 2012 as the effective date in which insurers must implement SBCs.

PHSA Section 2715 specifies that the appearance for the SBC must be in a uniform format that does not exceed 4 pages in length (which the NPRM has clarified to mean 4 pages front and back - therefore it is actually 8 pages) and may not include print smaller than 12 point font. Furthermore the contents must include various enumerated requirements designed to assist health insurance purchasers with their decisions. PHSA Section 2715 also requires the Secretary to consult with the National Association of Insurance Commissioners ("NAIC") to develop SBC standards.

In the NPRM, HHS adopted the NAIC form template ("Form") in its entirety. Representatives from Blue Plans participated in the NAIC working group. However, throughout the process, we advocated for SBC standards that would work from existing disclosure rules and would generally be more flexible, streamlined, and less costly to produce than the current proposed document. We also point out that during this process the NAIC’s primary focus was on developing the uniform template and not addressing the difficult implementation issues. As a result, we recommend that the agencies focus on the complexity of implementation in evaluating the NAIC's proposed SBC and in issuing final regulations.

All 39 Plans want applicants, enrollees and policyholders to understand their coverage options. Over the years we have assisted our members with their purchasing processes by providing detailed coverage and enrollment information and assisting employers in preparing summary plan descriptions ("SPDs") as required by ERISA. We also understand that methods of disclosing information to consumers is an evolving process and we are always looking for ways to better educate consumers. However, we believe that the SBC as currently proposed will not add significant value to the decision-making and/or purchasing process because, not only does the Form provide information that we already supply, but the SBC is too rigid and does not allow group health plans and issuers to adequately describe innovative plans that diverge from the standards in the Form – for example, value-based insurance design benefits. This will not only be misleading for purchasers but could potentially inhibit the creation of innovative benefit plan designs that are good for consumers and address rising health care costs. Additionally, the costs of implementation will be significant and will increase the cost of health insurance coverage in all markets.

BCBSA’s Major Concerns with the NPRM and Solicitation

We have thoroughly analyzed the NPRM and Solicitation of Comments and we believe that there are significant challenges with implementing the SBC requirements as proposed. Our major concerns with the proposed rule and our recommendations to the agencies are as follows:

- **Compliance Date**: The proposed date of compliance, March 23, 2012, is simply not possible given that the Form will require industry-wide changes to internal IT systems and system-wide changes to enrollment and renewal processes.
    - **Recommendation:** BCBSA recommends that Plans and employers be given 18 months after a final rule is issued to implement final requirements.
    - **Recommendation:** We urge the agencies to issue technical guidance as soon as possible indicating that the March 23, 2012 implementation date will be delayed, given it is not possible to make such major changes in this timeframe.
- **Form:** The Form requirements as proposed would be confusing to consumers, duplicative for employers, and prohibitively expensive due to the fact that there are thousands of health insurance options and policies in the market today each of which will require a Form. Each Form is administratively difficult to prepare, particularly the customized Coverage Examples ("CEs") and premium information requirements as proposed for each Form. We would also like a confirmation in the final rule that any final required SBC need not be printed in color, which would reduce administrative costs.
    - **Recommendation:** BCBSA recommends premiums as well as customized Coverage Examples (CEs) be deleted from the Form. The agencies are encouraged to work with employers and insurers to allow alternative mechanisms, some of which are the consumer tools in place today among Plan, which assist consumers with understanding their cost-sharing provisions and estimates for the costs of covered services or anticipated procedures. If CEs remain requirements, we recommend they be generic CEs and they be posted on the HHS website.
- **Timelines:** The timelines in which Forms must be delivered to shoppers, applicants, enrollees, special enrollees, and policyholders throughout the purchasing process are arbitrary and unworkable.
    - **Recommendation:** BCBSA recommends that all 7 day proposed timelines be revised to 30 days.
- **Duplicative Disclosures**: The Form is duplicative of other disclosure documents that are required to be provided, particularly in the large group and self-insured markets.
    - **Recommendation:** BCBSA recommends that large groups, including those that self-insure, be exempt from the rule.
- **Shoppers:** The NPRM requires issuers and group health plans send SBCs to "shoppers." However, it is administratively impossible to create an SBC until information is known about the potential purchaser and possible dependents.
    - **Recommendation**: BCBSA recommends that Plans that participate in the HHS web portal be deemed to be in compliance for shoppers in the individual as well as the small group market. The ACA did not establish requirements for Plans related to shoppers and this should be acknowledged in the final rule. Relying on the information on the HHS web portal for shoppers is a viable alternative to the proposed provisions.

- **Premiums:** The NPRM requires that the individual SBC include premium information. However, it is impossible to provide accurate premium information until an offer of coverage has been confirmed or renewed. To post amounts that are not applicable to the applicant is not meaningful and will be confusing to the consumer. Premiums can only be accurately quoted when all information has been submitted to the Plan and underwriting factors applied to calculate the final premium for the applicant who has completed the process.
    - **Recommendation:** BCBSA recommends that all SBCs not contain premium information. Premium information was not included in the Affordable Care Act as a required item.
    - **Electronic Delivery**: Although the NPRM allows insurers to deliver the Form electronically, the electronic delivery requirements with respect to individuals are overly restrictive,
    - **Recommendation**: BCBSA recommends that the final rule allow greater flexibility for delivery of electronic SBC; and
- **Existing Disclosures:** It is not clear whether state laws that already require similar disclosures are preempted by or coexist with the SBC requirements.
    - **Recommendation:** BCBSA recommends that the agencies clarify the SBC as it relates to existing state and federal disclosure laws.

These concerns and others constitute the foundation of our comments. We address these concerns and offer our recommendations in more detail below. We offer alternative models, which are attached, and processes for the SBC that we believe will be more efficient, less costly, and will continue to meet the objective of providing a summary document to applicants and covered policy or certificate holders. One of our attachments is the SBC as provided in the rule but with modifications which we believe are necessary to have accuracy in benefit descriptions. A second attachment is a new alternative to the proposed SBC which we believe will accomplish the same objectives as the proposed SBC but is more streamlined and allows for Plan flexibility in the entries for each benefit categories. The other attachments are examples of disclosure documents used in the marketplace today.

We believe that many consumers today already receive useful benefit summaries and have access to consumer tools to assist with their estimated costs of covered services. Many of our comments are intended to assure meaningful information is provided to consumers and reduce duplicative disclosures that result in higher costs for coverage.

BCBSA and Plans share a common goal that applicants, enrollees and policy and certificate holders should have a comprehensive summary of their coverage and benefits under their applicable health plan. Plans, and the small and large employer groups that we work with, frequently provide summaries or statements of coverage and benefits. Adding new materials to existing disclosures presents significant challenges and we do not believe the strict requirements under the NPRM add significant value to applicants, enrollees, policyholders and certificate holders. We recommend a more streamlined approach to the implementation of PHSA Section 2715.

One example of duplication is the FEHB program which requires health plans to make available "brochures" during enrollment and renewal. Within these brochures is a "Summary of Benefits and Coverage" that provides an outline of each plan's benefits and services and the amount the member would have to pay in those categories of services. We have also attached an example of such Summary from the BlueCross and BlueShield Federal brochure for your review. Also all members of the Federal

BlueCross and BlueShield options have access to an on-line tool that could serve as an alternative to a customized SBC with customized CEs.

BCBSA launched the "MyBlue Treatment Cost Estimator" on January 1, 2011. This consumer cost tool provides Service Benefit Plan members with cost estimates for common treatments at different providers within a given geographic area, helping members make better-informed, cost-conscious healthcare decisions. A member can log onto MyBlue Customer Service, available at www.fepblue.org, to access the tool. Once logged in, he or she can select the type of treatment and zip code to be provided with a results page listing cost estimates for the treatment at different providers within the area specified. The cost tool also indicates whether providers are designated as Blue Distinction Centers, a designated given by BCBSA to certain facilities that provide quality services when compared with others, so members can search for quality in addition to cost.

This consumer tool is working well. We recommend the agencies consider this tool and others in operation among Blue Plans today, as alternative mechanisms for customized CEs in all SBCs. We would be pleased to demonstrate to the agencies other on-line tools Plans have in operation today that assist Plan members in understanding estimates for selected anticipated procedures and how their cost-sharing features might work. These tools track the same objective of having CEs in the SBCs and are working today and are part of most Plan operations.

Another example is the Medicare Advantage program ("MA program") which requires a Summary of Benefits for each option. The Summary of Benefits provides descriptions of the benefits and services within a MA plan and compares the benefits of a specific MA plan to the benefits and services available in a traditional Medicare plan. The template for these Summaries of Benefits offer drop-down menus of options to Plans to insert text to insure accuracy of coverage descriptions. Although the MA summary is longer and more detailed than the proposed SBC, the drop down menus provide greater flexibility in the text to allow for more accuracy in the benefit descriptions than the rigid and standardized SBC Form in the NPRM.

In summary, we have found that issuers and group health plans already have well developed summaries of benefits and coverage for all of their available options along with a variety of useful consumer tools that help consumer anticipate costs for selected procedures and services. For individual and small groups, benefit summaries are also available today on the HHS Plan Finder.

BCBSA's detailed comments supporting each of our recommendations follow.

Detailed BCBSA Comments on the Notice of Proposed Rule Making

1. Applicability Date

We believe the March 12, 2012 implementation date is impossible to meet. When Congress drafted the SBC provision within the ACA, it intended for the Secretary to develop standards 12 months after the ACA was enacted (March 23, 2011) and for issuers and group health plans to implement SBCs 12 months after standards were published (March 23, 2012). Given the fact that the NPRM was significantly delayed and a final rule has not even been released, HHS should provide plans with additional

necessary time to prepare for SBC implementation. We recommend 18 months for compliance after the final rule is issued. Agency guidance is also needed now announcing a delay in the effective date.

Issuers and group health plans need this additional time to develop, produce and implement associated information technology changes to their internal IT systems. They will also need time to change their enrollment and renewal processes for thousands of customers who have health care options in the individual, small and large group market. The system changes and production lead times that are necessary to create SBCs for an effective date of March, 23, 2012 is impossible because SBCs are highly customized documents. In addition, the Form includes provisions that are not finalized such as essential health benefits ("EHB"), coding data and CEs. Requiring issuers and group health plans to implement provisions that are subject to change is costly and inefficient. Therefore we do not think that it makes sense to require SBC implementation until 18 months after the final rule is issued.

The issue is further problematic because of the civil penalties that apply if an issuer does not comply with the SBC requirements. Failure to provide a compliant SBC to even a portion of contracts could generate potentially enormous penalties. The PHSA Section 2723(c)(i) already imposes a civil penalty of $100 for each day for each affected individual. Moreover, Section 2715 established a new civil penalty of up to $1,000 per day for willful violations of the SBC rule. This penalty creates an unprecedented risk for issuers because they have virtually no lead time to comply.

BCBSA Recommendation: Plans should be given 18 months from the issuance of the final rule for compliance. While we believe it will be onerous for all of the insurance markets, we believe the large group market will have the biggest burden, followed by the small group market and then the individual market. Therefore we recommend that HHS also issue a press release (or other guidance, such as a Technical Release or Insurance Standards Bulletin) to immediately indicate that it intends to delay the March 23, 2012 effective date for the SBC final rule. This will keep issuers and employers from investing significant resources to come into compliance with a proposed SBC rule that is likely to change when finalized. HHS should also include the new delayed effective date in the final SBC rule when issued.

We recommend the following schedule for implementation:

- **Glossary** – Because the Glossary is a standard form that is not customized to each policy and may be supplied online, we think that this is the least onerous aspect of the SBC rule. We think it is reasonable for all markets (individual, small and large group) to supply the Glossary within 6 months after a final rule is issued. However, we support the provision of the Glossary on an earlier deadline only to the extent that as provided in this NPRM, it may be delivered via the Plan Finder or other websites and is clearly not tied to any particular coverage provided.
- **Individual** – Individual health plans should not have to implement the SBC rules until 18 months after the date on which the final rule is issued.
- **Small Groups** – Small group health plans should not have to implement the SBC rules until 18 months after the date in which a final rule is issued.
- **Large Groups** – We believe it is reasonable and necessary for HHS to completely exempt large group health plans, including self insured health plans and student health plans, from the SBC requirements. As we noted above, it is administratively problematic and costly to implement SBCs in the large group

market. This is because the large group market has highly customized plans and already provides expansive tools to assist purchasers, such as enrollment and renewal materials, SPDs and human resources personnel to answer questions. Generally large group health plans are defined as those with 100 or more employees.

While we urge the agencies to extend the compliance date, in the unfortunate event that HHS does not extend the March 23, 2012 date as recommended above, it should adopt a transition period in which group health plans and issuers will not be subject to any penalties if they have initiated a good-faith effort to comply with the SBC requirements.

2. Scope of the Rule: "Shoppers" vs. "Applicants"

The ACA states that SBCs are intended for "applicants, enrollees, and policyholders or certificate holders." However the NPRM also requires that issuers and group health plans provide SBCs to "shoppers." Shoppers are distinguishable from applicants because, unlike applicants who submit applications for coverage, shoppers are interested in but have not yet decided to apply for coverage. Shoppers are outside the intent of Congress, and will be able to rely on the HHS Plan Finder or other channels of information. However, we were pleased to see that if an issuer of individual health insurance policies participates in the Plan Finder HHS shall deem such issuers compliant with the SBC requirements (the "deeming rule").

Recommendation: We recommend that HHS completely eliminate any requirements related to issuers and group health plans providing SBCs to shoppers.

If shoppers are not completely excluded, then we recommend the deeming rule for the individual market be extended to shoppers in the small group market as well.

3. Timelines for Making the SBC Available to Applicants

The NPRM requires issuers and group health plans to provide an SBC within 7 days upon request and upon application. The NPRM also requires issuers and group health plans to provide an SBC within 7 days of a special enrollment period. We believe 7 days is not a reasonable amount of time to provide SBCs in both situations and is not required in the ACA.

Recommendation: Due to the fact that the proposed SBCs will need to be customized, we recommend that HHS provide issuers and group health plans with significantly more time to distribute an SBC. We recommend that HHS make a global change to the NPRM and in all instances where it established a 7 day timeline (i.e. upon request, upon application, upon special enrollment) that HHS expand it to 30 days. We note that this would be similar to the DOL rules which allow plans 30 days to deliver an SPD.

4. Requirements for Members/Participants

The NPRM requires issuers and group health plans to send SBCs to both the participant and the participant's beneficiaries - such as a spouse or dependent. If participants and beneficiaries reside at the same address, then an issuer or group health plan need only send one SBC. However if any one of these individuals resides at a different address

than the participant, the SBC must be sent to that individual at his or her last address on record.

The requirement that SBCs be sent to both the participant and the beneficiaries, including beneficiaries who do not reside at the participant's address, is costly and impractical. First, the issuer or group health plan enters into a contract for individual coverage with the participant, and not the beneficiaries and for group coverage the contract is with the employer or union. Second, issuers and group health plans do not routinely keep record of the addresses of all the individuals covered under a policy and therefore would not even know if a beneficiary resides at a different address. Third, if issuers and group health plans had to send SBCs to participants they would have to frequently update beneficiary data. In summation, this requirement would not add any value to the consumer and it would be both complex and expensive to implement.

Recommendation: We recommend that HHS require that SBCs be provided only to the participant. However if HHS insists on providing SBCs to beneficiaries who reside at different addresses than the participant, it should only be upon request.

5. SBCs are Duplicative and Unnecessary in the Large Group and Self-Insured Plan Markets

Certain group health plans have existing obligations under ERISA to send their participants an SPD which provides the participants with detailed information regarding their coverage option. Large groups and self- insured plans also provide sophisticated enrollment materials and different educational tools to employees so that they understand their coverage and make wise choices. As a result, we generally think that these markets should be excluded entirely from the obligation to deliver SBCs. If exclusion is not provided, then such groups should be given greater flexibility.

Recommendation: We generally recommend that HHS exempt the SBC requirements with respect to insured and self insured large group health plans. If HHS ultimately decides to continue to require group health plans to implement SBCs, we believe HHS should deem large group health plans to have satisfied the SBC requirements if such plans have included the relevant SBC information within their SPDs or enrollment materials in one contiguous and prominent location. In so doing, HHS should not require these plans to comply with SBC formatting restrictions.

We alternatively recommend that insured and self insured large group health plans need not distribute SBCs. Instead they could include a conspicuous statement in the forefront of their SPD that all enrollees may request an SBC at a specified website or phone number.

6. Renewals/Changes to Contract Terms

The NPRM states that an insurer must provide an SBC: (1) when the policy is renewed or reissued; (2) if a written application is required, then SBCs must be provided no later than the date materials are distributed; and (3). for automatic renewals, the SBC must be provided at least 30 days in advance prior to the first day of the new policy year.

These requirements are problematic because it is common practice that health plans and purchasers, often large as well as small groups, finalize their contract terms shortly

before the next new plan year. Some plans even make changes to their policies after the policy becomes effective. Therefore it is not always administratively possible for Plans to provide SBCs 30 days in advance of a given renewal.

Furthermore, in the individual market, often policies do not have a defined policy year, but instead run month to month. In such an instance it would not make sense for an issuer to provide policyholders a new SBC each month as the terms of the policy remain constant.

Recommendation: We recommend the final rule accommodate these renewal situations by including a provision such as the following:

> *"The SBC must be provided at renewal 30 days in advance of the new contract year or when the materials are distributed during the open enrollment period. However, when a group purchaser in the large or small group market, or individual policyholder in the individual market, makes a change to their applicable policy and the Plan agrees to such changes prior to the next contract year within that 30 day period of time, or even within a reasonable time after the start of the new contract year, then the SBC must be delivered within 30 business days after the final contract terms are agreed to by the purchaser and the issuer. Such a delay in issuing the SBC to the policyholders or certificate holders will not cause the issuer to be treated as out of compliance with the requirements of this rule."*

7. Material Modifications

The NPRM requires issuers and group health plans to distribute a notice of material modification when there has been a material change in the policy during the plan year. Such notice must be sent 60 days in advance of the effective date of the modification.

It is unclear exactly what constitutes a material modification and with the SBC rules not yet finalized, we do not think it would be appropriate to require issuers and group health plans to provide material modification notices every time HHS changes the SBC required content. We also do not think it would be appropriate to apply the 60 day advance notice requirement to circumstances where a state benefit mandate imposes a change that must be reflected in the SBC.

Additionally, individual policyholders and group health plans frequently make mid year changes. An individual may have the right to voluntarily amend his or her individual policy during the policy year. For example, an individual may no longer be able to afford his or her health coverage and therefore amends their coverage by decreasing coverage, rather than terminating their coverage. Similarly, regarding group health plans, if an employer wants to impose a benefit improvement to its employees' health coverage, the employer should be able to do so retroactively or immediately and not have to wait 60 days to implement the change after they send a material modification notice. The final rule should not hinder the implementation of more favorable group health coverage.

Recommendation: We recommend that the agencies allow policyholders in the individual market to change their coverage outside of their renewal date (if there is one) as agreed to by their Plan and we also recommend group health plans be allowed to implement increases in coverage options either immediately or retroactively and not

have these situations generate an SBC under material modification provisions. A SBC should be required only when the Plan generates a material modification to the policy during the plan or contract year. This would then provide for a more reasonable notification process when the Plan, not the purchaser or the individual policyholder, generates a material modification to a policy during the contract or policy year.

8. Premium Information Included in the SBC

The NPRM has added the requirement that premium information be included in the SBC despite the fact that Congress omitted this requirement from PHSA Section 2715. We note that it is difficult to include accurate premium information until an offer of coverage has been confirmed or the issuer or group health plan has completed its renewal process. Furthermore, in the individual market, premiums are assigned only after an offer of coverage has been made and often depends on factors such as age, gender and smoking status. Moreover in the group market, employers usually pay a portion of the premium and therefore any estimate would not reflect the participant's actual out of pocket costs. We also note that it is unnecessary to provide premium information in the SBC because when rates are finalized, it is already customary for an issuer or group health plan to supply this information.

Recommendation: In the group and individual market, we strongly recommend that HHS eliminate premium and cost information from the SBC format and highlight that the ACA did not require this provision.

9. Electronic Delivery

The electronic delivery rules significantly restrict when issuers and group health plans can provide electronic rather than hard copy SBCs to individuals. For example, in the individual market an issuer may only deliver an SBC to a policyholder if the policyholder (1) requests information or an application electronically; (2) submits an application electronically; or (3) specifically requests that he or she be sent the information or application electronically. And, for ERISA plans in the group market, SBCs may be provided electronically to enrollees if: (1) the individual provides affirmative consent; or (2) without affirmative consent if the employee has access to electronic documents at his or her workstation. These rules come from the safe harbor under the DOL rules on electronic disclosure.

We believe these proposed rules are overly restrictive and do not accommodate the fact that throughout all demographics (income, age, ethnicity) individuals have substantial access to information delivered electronically - whether it be through email or the internet. HHS should facilitate electronic delivery because it is fast, accurate and efficient. It will also help control rising health care costs and further assist individuals in the purchasing process by giving them an easy to access, easy to navigate, permanent record of their coverage options.

Recommendations: We note that the electronic delivery rules that apply to issuers delivering to group health plans are significantly more flexible. The NPRM allows issuers to provide SBCs electronically to group health plans if: (1) it is in a format readily accessible by the plan sponsor; (2) the issuer would provide a paper form free of charge upon request; and (3) if the electronic form is an internet posting, the issuer timely advises the plan either through hard copy or through email that the SBC is available on the internet and states the specific website. We believe that HHS should extend these

rules where the group health plans and issuers have to send SBCs to individuals. We recommend that HHS allow for more flexible electronic delivery to reduce the costs of compliance.

10. Interaction with State Laws/Premiums

It is unclear what happens when a state law requires insurers to disclose the same information that also must be disclosed in the SBC. One example is in California where issuers in the individual and small group market must provide a Uniform Matrix that summarizes and compares coverage options. Health and Safety Code Sec. 1363. Many of the requirements of the Uniform Matrix are the same as the requirements within the SBC, such as providing information on co-pays and co-insurance. Another example is South Dakota which has a rule which requires insurers to supply an outline of coverage with each insurance policy it issues. S.D. Codified Laws Sec. 58-33A-5, 6. We note that the required information in the outline of coverage overlaps substantially with the SBC but also requires other disclosures. Furthermore if issuers and group health plans send both SBCs and state required disclosures, purchasers will receive different documents with different labels and information that describe the same plan. This will inevitably confuse participants. Instead the agencies should issue clarification on preemption issues; otherwise state regulators are likely to insist on their own documents even where they will cause duplication and consumer confusion.

Recommendation: We recommend that the agencies review state requirements and clarify preemption issues as soon as possible. We alternatively recommend that the agencies incorporate flexibility into the Form so that in the event that a state law has its own required disclosure, insurers can incorporate state mandated requirements into the Form.

11. SBCs for Every Option at Enrollment

The proposed rule currently requires an issuer or group health plan to provide an SBC for each plan option. A plan option could include each different cost sharing level and coverage tier (i.e. single, single plus spouse, single plus family) for each type of coverage (e.g., PPO, HMO). A typical plan with PPO and HMO options, with 3 different cost sharing levels and 3 coverage tiers would require 18 SBCs alone. Moreover, at the time an individual in a group plan is initially eligible, that person must receive an SBC for every option they are eligible for. The abundance of SBCs would likely overwhelm and frustrate purchasers rather than assist them in the process. Additionally it goes against the Administration's policy to conserve paper by delivering hard copies only when it is necessary to do so.

Recommendation: We recommend the agencies significantly streamline these delivery requirements.

We recommend that the agencies allow issuers and group health plans to include all of the cost sharing levels and coverage tiers of one plan option on one SBC form. This would accommodate more innovative designs such as wellness plans which often provide cost reductions (such as lower cost shares or deductibles) for individuals who participate in certain programs that promote healthy behavior. We also recommend that the agencies permit issuers and group health plans to voluntarily include plan identification numbers on the SBC to assist their implementation of delivery requirements.

With respect to initially eligible individuals in group coverage, we recommend that the agencies allow group health plans and issuers to provide an SBC for one plan option (i.e. the PPO) and then to provide other SBCs for other plan options upon request.

12. SBCs in a Non-English Language

PHSA Section 2715 requires that the SBC be presented in a "culturally and linguistically appropriate manner" which means that issuers and group health plans must provide interpretive services and SBCs upon request in non-English languages. We recognize the importance of providing non-English speaking populations with equal access to information about their health care coverage. However we are concerned that if each issuer and group health plan individually tries to interpret the SBC into the relevant languages, the SBCs will no longer be uniform in content. We also understand that some preliminary attempts to translate the SBC as offered in the proposed rule alter the format of the standardized document presenting new challenges to Plans.

Recommendation: We recommend that HHS provide the SBC templates in non-English languages to maintain a uniform template. There is precedent for this in the Medicare Advantage program where CMS provides translated versions of certain model documents to assure accuracy in the designated languages and reduce individual Plan costs.

13. Ability to Contract Who Performs Delivery Requirements

The NPRM imposes joint obligations on the issuer and group health plan to provide SBCs to plan participants in the group market. Our experience is that many employers want to deliver plan documents to their employees without the help of the issuer and as a result it would be unreasonable to hold an issuer liable for a responsibility that the employer does not want to delegate.

Recommendation: We believe that group health plans and issuers should have the right to enter into agreements regarding who shall satisfy the SBC delivery requirements. Furthermore to the extent that the parties agree, the non-responsible party should not be held liable for the other party's failure to deliver the SBCs.

BCBSA Additional Comments on the "Solicitation of Comments"

We commend the agencies for issuing the Form simultaneously with the NPRM, in the Solicitation of Comments. We have relied on it to understand the intent of the rule in regards to implementing SBC requirements. We offer our suggestions, which we believe will improve the Form by making it easier for applicants, enrollees and policyholders to use and easier for issuers and group health plans to implement. We also ask that if there are conflicting provisions in the final rule and the Solicitation of Comments, that the provisions in the NPRM prevail.

1. Glossary

We note that while a glossary of terms could serve applicants, enrollees and policyholders by helping them better understand the terms of their coverage, the Glossary may also confuse the customers if the Glossary’s definitions contradict the way such terms are used in the plan document.

Nevertheless, assuming issuers and group health plans can satisfy the Glossary requirement by posting it on their websites, we believe the Glossary will be relatively easy to implement after the final rule is issued.

Recommendation: We recommend that HHS clarify that although issuers and group health plans may post the Glossary to their websites or choose to mail copies of the Glossary to enrollees and policyholders upon request, they do not have a legal obligation to do so because the Glossary is a government issued document that agencies, such as HHS and the DOL, will have available on their websites.

We ask HHS to add a disclaimer to the Glossary to explain to applicants, enrollees and policyholders that the Glossary definitions apply to health insurance in general but may not be applicable to the terms in a particular policy. For example, some policies might not allow or have balance billing features or may define out-of-pocket differently than the Glossary. We recommend the following language:

> *"This Glossary has been developed according to the requirements under Section 2715 of the Public Health Service Act. While it is intended to be educational, the terms and definitions in this Glossary may not be the same as the terms and definitions within your health plan or policy or state law. Please consult your plan documents if you have specific questions regarding the terms and definitions in your policy."*

2. Distribution of Freestanding Document

The Form requires issuers and group health plans to issue the Form to each applicant as a freestanding document. This is difficult because it is administratively inefficient for an issuer or group health plan to distribute substantially similar documents separately. Additionally, we believe it makes the most sense for applicants, enrollees and policyholders to receive their plan information at one time in an organized systematic manner rather than to receive plan documents at scattered points throughout the purchasing process. We also recommend that the form be limited to the four pages specified in the ACA and not eight pages (four pages double sided). A four page SBC would better serve the consumer because we generally believe that the average consumer would not be willing to read or readily comprehend anything much longer. This would also assume that an alternative mechanism is developed to provide CEs to consumers.

Recommendation: We recommend the final rule ease the burden of distribution by eliminating the requirement that the SBC be a freestanding document and instead allow issuers and group health plans to insert or attach the Form to other materials at the time of application.

We also recommend the final rule allow issuers and group health plans to bar code or use other labeling techniques for the documents to further assist with distribution processes.

3. Specific Recommendations to Form Language

"Policy Period" - We recommend the final rule delete the term “policy period” so that the Form does not need to be updated on a monthly basis to reflect the month in which the person requested the SBC and the month the contract year ends. Deleting the term

“policy period” also takes care of situations where the policy does not have a policy period specifically as it found in some individual policies among Plans.

"Medical Necessity" – We recommend HHS use a more detailed definition than the current one which is vague and thereby misleading to consumers.

"Type of Coverage" - We recommend that the template be reworded to read "Enrollment Options." Plans would then fill in all the available tiers, such a "Single and Family", or "Single, Two Adults, Adult and one Child, or Family" as applicable to that SBC.

Reference to the Glossary—We recommend that HHS revise the disclaimer language on the SBC that refers the purchaser to the Glossary. Instead we recommend that HHS refer purchasers to the plan documents or the plan websites because the Glossary definitions will most likely not match the plan definitions.

Deductibles, Out of Pocket Limit – We recommend that if the SBCs are electronic, the instructions allow a drop down menu for all the variations in the marketplace for definitions of deductibles and out of pocket dollar limits.

Does the Plan use a Network of Providers- We recommend that if the SBCs are electronic, the instructions allow a drop down menu to show differences in network configurations.

Referrals to Specialists- We recommend that if the SBCs are electronic, the instructions allow a drop down menu for when referrals are commonly needed and when they are not required as some plans only require referrals for certain specialists and not others.

Common Medical Event—We recommend removal of "chemotherapy" as an example of a specialty drug.

Separate Lab and X-Ray Services – We think that it is inappropriate to group these services together because they frequently have different cost sharing.

Habilitation Services – We recommend removing this category from the SBC and adding more commonly used covered benefit categories, such as prosthetics, orthotics and allergy services because there are very specific criteria for habilitation services and it is not a commonly provided benefit.

Coverage Examples (“CEs”)— We recommend deleting the CE requirements from being included in the SBC, simplifying the CEs, and creating alternative mechanisms to implement this requirement. The ACA requires an issuer or group health plan to provide only two CEs, one for pregnancy and one for a chronic disease. The NPRM speaks to adding up to six CEs including pregnancy, diabetes and breast cancer. We do not think that additional CEs will serve the goal of HHS which is to "illustrate benefits provided under the plan or coverage for common benefits and scenarios." This is because CEs rely on assumptions provided by HHS based on industry wide averages.

These assumptions include: course of treatment, length of treatment and the cost of treatment. We note that averages will never accurately illustrate an individual's cost sharing because illnesses, particularly complex diseases (such as breast cancer) are

unique to each patient. Furthermore, the cost of treatment may vary significantly based on geographic region, the provider, and the health plan. Generally, we want to provide our purchasers with accurate information and not mislead them in any way. However we are particularly concerned with CEs because they will not only mislead purchasers, but they will mislead certain purchasers, who may already have a defined medical condition needing treatment. These are the individuals that will look to the CEs and rely on the cost sharing estimates. The more inaccurate the cost sharing estimates are, the greater the detriment to this vulnerable population.

Therefore we ask that HHS either delete the CEs altogether or limit CEs to the statutorily mandated number – two – one for pregnancy and one for chronic disease and have them be generic in nature. Next we recommend that HHS choose a chronic disease that is generally less complicated and more common, and that HHS not use breast cancer. We further think that when HHS establishes the parameters of CEs, it should limit the simulation to a course of treatment that lasts no longer than one year. This will control the potential for variables that will inevitably occur during the course of treatment over the long term and will thereby promote accuracy in the CEs. Finally we ask that HHS incorporate bold warning language (and possibly even graphics that indicate caution) in a prominent location on the CE coverage label to limit the extent in which individuals will rely on the estimated cost sharing data.

Finally we recommend that HHS and insurers work together to find an alternative mechanism to provide consumers with CEs so that the programming costs and resources and other complexities with compiling these by products are reduced. Many Plans already uses cost estimator tools that can serve as an alternative to the CEs as proposed. One such cost estimator tool, such as the one currently made available to our Federal members, has a range of selected medical cost estimates in nearly every U.S. zip code. While the tool currently provides ranges for 59 common, elective medical procedures at hospitals and other care centers BCBSA plans to expand its capabilities significantly in upcoming months.

Excluded Services & Other Covered Services - The Form includes a list of "services your plan does not cover." This list includes: Acupuncture, Bariatric Surgery, Non-emergency care when travelling outside the US, Chiropractic Care, Cosmetic Surgery, Dental Care (adult), Hearing aids, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, and Weight Loss programs. We think this list is inaccurate, misleading and too rigid. First, the list fails to include the most obvious and prominent exclusion to covered services among health plans – experimental and investigational procedures. Second, the categories within the list are broad and do not accommodate exclusions. For example, infertility treatment encompasses a variety of treatments and procedures and some treatments are generally covered by health plans. An additional example is foot care; while routine foot care is often excluded for the general population, it is often covered for individuals with diabetes. Third, the list is misleading because while many of these services are generally excluded under medical plans, employers often buy supplemental policies that include these services. The most obvious example is dental care. Fourth, some treatments may be covered but on a limited basis, such as chiropractic care and acupuncture.

Recommendation: We recommend that HHS add experimental and investigational procedures to the list of excluded services. We also recommend that HHS generally incorporate flexibility into this list. HHS should indicate that while some of these services

may be excluded under the medical plan, they may be offered in a supplemental plan, such as dental or vision services. HHS should also explain that these are expansive categories and the plan may have exceptions or offer these treatments on a limited basis.

We have attached a new alternative SBC Form template for your consideration. We have also attached Plan summaries used in today's market that we thought would be useful for the agency to review also as alternatives. We highly recommend that HHS consider other formats we have suggested. We think that it streamlines SBC requirements in a way that will be more helpful for health insurance purchasers.

Implementation Costs

Federal Employees Health Benefits Program

We understand that issuers participating in the FEHB program also must comply with the SBC rules. BCBSA has two options in the FEHB program—a Standard and Basic option with a calendar year policy year. Furthermore applicants have two policy choices – single and family – and the premium rates depend on which option the applicant applies for.

If BCBSA is to issue SBCs to our enrolled federal members at renewal or during the open season, we estimate that an 8 page SBC document (4 pages double sides) would need to be printed for 5.2 million members at annual total cost of $250,000 (excluding production costs for the variations needed). Assuming we do not mail the Form to children under 18, we also estimate that it will cost an additional $600,000 to mail this document to 4.26 million persons. Therefore it would approximately cost a total of $850,000 to print and mail SBCs. We note that requiring participants in the FEHB program to distribute millions of Forms contradicts the Office of Personnel Management's "going-green" initiative which aims to decrease costs by increasing the Federal Government's reliance on electronic document delivery instead of mailing the documents in hard copy.

Recommendations: We recommend that HHS align the SBC rules with OPM's initiative and allow participants in the FEHB program to deliver the Form electronically unless a member requests a hard copy.

Specific Plan Cost Examples:

The chart below is just a mere sample of data collected from the Plans regarding what their estimated implementation costs would be. This estimate assumes an effective date of March 23, 2012, and includes SBC requirements for the individual, small, and large group market. These are estimates only and do not include any additional costs that will occur if the final rule amends the requirements. These estimates are reflective of the costs that some of our 39 plans may incur and some Plans did not report estimates in all section of the chart. We highly recommend that HHS incorporate more flexible electronic delivery rules because this will bring down the cost of implementation considerably.

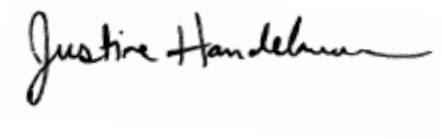
Summary of Benefits and Coverage Estimated Implementation Cost

BCBS Plan	Covered Lives	Project Cost Effective date 3/23/2012	Project Costs if Effective with an Extension to the Current Compliance Date	Annual Ongoing Plan SBC and Glossary Cost	Annual Ongoing Plan Costs attributed to hiring additional staff
Plan A	Fully-insured =501K Self-funded =1.6M	$1.8M	$1.5M = Savings of approx. $300K	$350K	$200K
Plan B		$3.9M	$2.9M = Savings of approx. $1.0M		
Plan C	Fully-insured =592K Self-funded = 922K	$1.9M	$1.9M	$447K	$259K
Plan D	Fully-insured =12.0M Self-funded =14.5M	$3.5M	Unknown	$59M	Unknown
Plan E	$1.4M	$1M (IT cost)		$1M (print/postage) $50K (IT development/maintenance)	$100K –IT resources hiring $100K- business resources hiring
Plan F	Fully-insured =1.9M Self-funded =3.0M	$6.2M	$4.7M	$915K	$357K
Plan G	Fully-insured =1.2M	BCBS, MA believes the	$1.9M	$4.2M	$675K

	Self-insured =1.5M	required operational and system changes are not achievable by effective date.			
Plan H		$310K			
Plan I	Fully-insured = 1.2 M Self-funded = 1.8M	$3.3M (IT/project cost)[1]	NA	$2.0M (print/postage)[2]	
Plan J		$2.5 - $3.0M			
Plan K		$1.5 to $2.0M Start up only			

Thank you for the opportunity to provide comments on this significant rule. Questions on these comments may be addressed to Jane.Galvin@bcbsa.com .

Sincerely,



Justine Handelman
Vice President, Legislative and Regulatory Policy

Attachments:

Revised SBC template
Suggested Alternative SBC Format
FEHP Summary Page
Sample Plan Documents

[1] This estimate does not include additional cost to meet March 23, 2012 effective date or additional resources that may be necessary to implement.

[2] Estimate includes the requirement to issue as a stand-alone document. Estimate does **not** include: (1)"On-demand" request (2) Duplicate mailings (3)On-going testing and resource charges for all application and coding changes to ensure future enhancements are compliant with regulation.

Insurance Company 1: PPO Plan 1

printed on: 1/1/2011

Summary of Coverage: What this Plan Covers

Plan Type: PPO

This is not a policy. For more details, see your employer or contact your health plan at www.insurancecompany1.com or by calling 1-800-xxx-xxxx. This document is a summary of some features of specific options offered under a plan.

Medical Benefits		In-Network		Out-of-Network	
		Single	Family	Single	Family
Annual deductible	Tier 1	$1,000	$2,000	$2,000	$4,000
	Tier 2	$1,500	$3,000	$3,000	$6,000
	Tier 3	$2,000	$4,000	$4,000	$8,000
	Tier 4	$2,500	$5,000	$5,000	$10,000
		You must pay all of the costs for covered services up to the specific deductible amount before this plan begins to pay for additional covered services.			
Other deductibles - *Prescription drug deductible*		$500	$1,000	$1,000	$2,000
Coinsurance		20%	20%	40%	40%
Out–of–pocket limit		$3,000	$6,000	$7,500	$15,000
		The out-of-pocket dollar limit is the most you could pay during a policy period for your share of the cost of covered services. The following items do not count toward your out-of-pocket limit: co-payments for covered services, premium, balance-billed charges, covered prescription drugs, and health care services this plan doesn't cover.			
Annual dollar limits		**There is no annual dollar limit on what the insurer pays** for covered services**.** The chart starting on page 2 describes any dollar limits on what the insurer will pay for specific covered services, such as office visits.			
Provider network		**This plan uses a network of providers.** See www.insurancecompany.com for a list of participating doctors and hospitals. If you use an **in-network** doctor or other health care provider, this plan will pay some or all of the costs of covered services. You may use health care providers that aren't in-network providers, but you may pay more. Plans use the term **in-network**, **preferred**, or **participating** for providers in their network.			
Referrals for specialty care		You can see the **specialist** you choose without permission from this plan but there could be a difference in your costs if they are in-network or out-of-network specialists.			
Excluded services		Some, but not all, of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section. Please refer to your Plan documents for a complete list of covered, limited, and excluded services.			

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren't clear about any of the terms used in this form, see the [reference specific plan document} or www.insurancecompany.com.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, 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 an **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**.) Some plans do not have balance billing features.
- This plan encourages you to use **in-network providers** by charging you lower deductibles, co-payments and co-insurance amounts.

	Covered Services	Your cost if you use a	
		In-Network Provider	Non-Network Provider
Office visits	Primary care visit to treat an injury or illness	$35/visit	40%
	Specialist visit	$50/visit	40%
	Other practitioner office visit (e.g., nurse practitioners, physician assistants, etc)	20%	40%
	Preventive services (e.g., screenings/ immunizations)	No charge	$30/visit
Laboratory services	Diagnostic tests (e.g., x-ray, blood work)	No charge	40%
	Imaging services(CT/PET scans, MRIs)	No charge	40%
Prescription drugs	Retail Rx purchases	After $500 deductible: $10/generic drugs; $25/formulary brand drugs; $50/non-formulary brand drugs	After $1,000 deductible: Same as in-network plus 25% of allowed amount
	Mail order Rx purchases	After $500 deductible: $20/generic drugs; $50/formulary brand drugs; $100/non-formulary brand drugs	
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20%	40%
	Physician/surgeon fees	20%	40%
Emergency services	Emergency room services	$100 (waived if admitted to hospital) plus 20%	
	Emergency medical transportation (e.g., ambulance)	20% ($5,000 maximum per calendar year)	
	Urgent care services	20%	40%

	Covered Services	Your cost if you use a	
		In-Network Provider	Non-Network Provider
Hospital services	Facility fee (e.g., hospital room and board)	20%	40%
	Physician/surgeon fee	20%	40%
Mental health and substance abuse services	Outpatient services	20% for serious mental illness $30/visit up to 12 visit/year for non-serious mental illness	40% for serious mental illness 40% for non-serious mental illness
	Inpatient services	20% for serious mental illness 30 inpatient days/year for non-serious mental illness	40% for serious mental illness 40% for non-serious mental illness
Maternity	Prenatal and postnatal care	20%	40%
	Delivery and hospital services	20%	40%
Recovery/other special health needs	Home health care services	20%, up to 120 visit per calendar year	40%
	Outpatient rehabilitation services	20%, up to 20 visits per calendar year	40%
	Outpatient habilitation services	20%, up to 20 visits per calendar year	40%
	Skilled nursing care in a rehab facility	20%	40%
	Durable medical equipment used at home	20%	40%
	Hospice service for the terminally ill	20%	40%
Pediatric dental/eye care	Routine eye exams	No charge; one exam every two years	Not Covered
	Eyeglasses	Not Covered	Not Covered
	Dental check-ups	Not Covered	Not Covered
Other services (this isn't a complete list. Check your policy for other covered services and your costs for these services.)	Acupuncture	20%	40%
	Chiropractic services	20%	40%
	Wellness programs	No charge	20%
	[other – add]		
	[other – add]		

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Routine care when traveling outside the U.S.
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Specialized infertility treatment (e.g. in vitro-fertilization)
- Long-term care services
- Routine eye exams (Adult)
- Routine foot care except for diabetics
- Routine hearing tests
- Weight loss programs

Your Rights to Continue Coverage:

You can keep this coverage (although benefits and premiums may change) as long as you pay your premium unless one or more of the following happens:

- You commit fraud
- The insurer stops offering policies in the state
- You move outside the Plan's service 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 to question or disagree with a denial of coverage for claims or services under this health insurance. Call 1-800-XXX-XXXX or visit www. Xxxxxxxxxxxxx.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-XXX-XXXX or visit www. Xxxxxxxxxxxxx.gov.

Alternative Summary of Benefits and Coverage

Blue Value: Blue Cross Blue Shield of X [or logo]

Summary of Coverage: What this Plan Covers **Plan Type**: PPO

This is not a policy. For more details, see your employer or contact your health plan at www.bcbsX.com/BlueValuePPO or by calling 1-800-xxx-xxxx. This document is a summary of some features of specific options offered under a plan.

MEDICAL BENEFITS	[PRODUCT NAME] IN-NETWORK		OUT-OF-NETWORK	
	Single	**Family**	**Single**	**Family**
Annual Deductible [per calendar year]	~~$1,000~~ $1,500 $2,000 $2,500	~~$2,000~~ $3,000 $4,000 $5,000	~~$2,000~~ $3,000 $4,000 $5,000	~~$4,000~~ $6,000 $8,000 $10,000
	You must pay all costs for covered services up to the deductable amount before this health insurance plan begins to pay for additional covered services.			
Other Deductibles *- Rx drug deductible*	$500	$1,000	$1,000	$2,000
Coinsurance	20%	20%	40%	40%
Out-of-Pocket Limit	$3,000	$6,000	$7,500	$15,000
	*The **out-of-pocket** dollar limit is the most you could pay during a policy period for your share of the cost of covered services.* *The following items do not count toward your out-of-pocket limits: premium, copayments for covered services, balance-billed charges, prescription drugs, and health care services this plan does not cover.*			
Annual Dollar Limits	*There is no overall **annual dollar limit** on what the plan will pay for covered services.* *The chart starting on page 2 describes any dollar limits on what the insurer will pay for specific covered services, such as office visits.*			
Provider Network	*This plan uses a **network of providers**. For a list of participating doctors and hospitals, see www.bcbsX.com or call 1-800-xxx-xxxx.* *If you use an **in-network** doctor or other health care provider, this plan will pay some or all of the costs of covered services. You may use health care providers that aren't preferred providers, but you may pay more.* *Plans use the terms **in-network, preferred,** or **participating** to refer to providers in their network.*			
Referrals for Specialty Care	*You can see the specialist you choose without permission from this plan, but there could be a difference in your costs if they are in-network or out-of-network specialists.*			
Excluded Services	*Some, but not all, of the services this plan doesn't cover are listed in the "Excluded Services and Other Covered Services" section on page 4. Please refer to your Plan documents for a complete list of covered, limited, and excluded services.*			

Alternative Summary of Benefits and Coverage

Blue Value: Blue Cross Blue Shield of X [or logo]

Summary of Coverage: What this Plan Covers **Plan Type**: PPO

* **Co-payments** are fixed-dollar amounts (e.g., $15) you pay for covered health care, usually when you receive the service.
* **Coinsurance** 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 coinsurance payment for 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 an **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.**)
* This plan may encourage you to use **in-network providers** by charging you lower deductibles, copayments and coinsurance amounts.

COVERED SERVICES	Your Costs if You Use a: In-Network Provider	Non-Network Provider
Office Visits		
Preventive services (e.g., screening/immunizations)	No charge	40%
Primary care visit to treat an injury or illness	$20/visit	40%
Specialist visit	$40/visit	40%
Other practitioner office visit (e.g., nurse practitioners, physicians assistants, etc.)	$20/visit	40%
Laboratory Services		
Diagnostic test (e.g., x-ray, blood work)	20%	40%
Imaging services (e.g., CT/PET scans, MRIs)	20%	40%
Prescription Drugs		
Retail Rx purchases	After $500 deductible: $10/generic drugs; $25/formulary brand drugs; $50/non-forumlary brand drugs	After $1,000 deductible: Same as in-network plus 25% of allowed charges
Mail Order Rx Services	After $500 deductible: $20/generic drugs; $50/formulary brand drugs; $100/non-forumlary brand drugs	

Questions: Call 800-xxx-xxx or visit us at www.bcbsx.com
If you aren't sure about any of the terms used in this form, see [reference specific plan document] or www.bcbsx.com

Alternative Summary of Benefits and Coverage

Blue Value: Blue Cross Blue Shield of X [or logo]

Summary of Coverage: What this Plan Covers **Plan Type**: PPO

COVERED SERVICES	Your Costs if You Use a: In-Network Provider	Non-Network Provider
Outpatient Surgery		
Facility fee (e.g., ambulatory surgery center)	20%	40%
Physician/surgeon fees	20%	40%
Emergency Services		
Emergency room services	$100 (waived if admitted to hospital) plus 20%	
Emergency medical transportation (e.g., ambulance)	20% ($5,000 maximum PCY)	
Urgent care services	20%	40%
Hospital Services		
Facility fee (e.g., hospital room and board)	20%	40%
Physician/surgeon fees	20%	40%
Mental Health and Substance Abuse Services		
Outpatient services	20% for serious mental illness $30/visit up to 12 visit/year for non-serious mental illness	40% for serious mental illness 40% for non-serious mental illness
Inpatient services	20% for serious mental illness 30 inpatient days/year for non-serious mental illness	40% for serious mental illness 40% for non-serious mental illness
Maternity		
Prenatal and postnatal care	20%	40%
Delivery and hospital services	20%	40%
Recovery/Other Special Health Needs		
Home health care services	20%, up to 120 visit per calendar year	40%
Outpatient rehabilitation services	20%, up to 20 visit per calendar year	40%
Outpatient habilitation services	20%, up to 20 visit per calendar year	40%
Skilled nursing care in a rehab facility	20%	40%

Alternative Summary of Benefits and Coverage

Blue Value: Blue Cross Blue Shield of X [or logo]

Summary of Coverage: What this Plan Covers **Plan Type**: PPO

COVERED SERVICES	Your Costs if You Use a: In-Network Provider	Non-Network Provider
Recovery/Other Special Health Needs		
Durable medical equipment used at home	20%	40%
Hospice service for the terminally ill	20%	40%
Pediatric Dental/Eye Care		
Routine eye exam	No charge; one exam every two years	Not covered
Eyeglasses	Not covered	Not covered
Dental check-ups	Not covered	Not covered
Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)		
Acupuncture	20%	40%
Chiropractic Services	20%	40%
Wellness benefits	No charge	20%
[other - add]		
[other - add]		

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

* Routine care when traveling outside the U.S.
* Cosmetic surgery
* Dental care (adult)
*Specialized infertility treatment (e.g., in-vitro fertilization
* Long-term care
* Routine eye exams (adult)
* Private-duty nursing
* Hearing aids
* Routine hearing tests
* Routine foot care, except for diabetes
* Weight loss programs

Your Rights to Continue Coverage

You can keep this coverage (although benefits and premiums may change) as long as you pay your premium unless one or more of the following happens:

* You commit fraud
* The insurer stops offering policies in the state
* You move outside of the Plan's service 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 to question or disagree with a denial of coverage for claims under this health insurance. Call 1-800-xxx-xxxx or visit www. bcbsX.com.
* An **appeal** is a request for your health insurer or plan to review a decision or grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at 1-800-xxx-xxxx or visit www. xxxxx.gov.

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2011

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $350 per person ($700 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: Nothing for preventive care; 15%* of our allowance; $20 per office visit for primary care physicians and other health care professionals; $30 per office visit for specialists Non-PPO: 35%* of our allowance	30-31
Services provided by a hospital:		
• Inpatient	PPO: $250 per admission Non-PPO: $350 per admission, plus 35% of our allowance	68-70
• Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	71-74
Emergency benefits:		
• Accidental injury	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Ambulance transport services: Nothing	80-81
• Medical emergency	PPO and Non-PPO: 15%* of our allowance for emergency room care; Regular benefits for physician and hospital care* provided in settings other than the emergency room Ambulance transport services: $100 per day for ground ambulance (no deductible); $150 per day for air or sea ambulance (no deductible)	80, 82-83
Mental health and substance abuse treatment	In-Network (PPO): Regular cost-sharing, such as $20 office visit copay; $250 per inpatient admission Out-of-Network (Non-PPO): Regular cost-sharing, such as 35%* of our allowance for office visits; $350 per inpatient admission, plus 35% of our allowance	84-86
Prescription drugs	Retail Pharmacy Program: • PPO: 20% of our allowance generic/30% of our allowance brand-name; up to a 90-day supply • Out-of-Network (Non-PPO): 45% of our allowance (AWP); up to a 90-day supply Mail Service Prescription Drug Program: • $10 generic/$70 brand-name per prescription; up to a 90-day supply	87-97
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	56, 98-102
Special features: Flexible benefits option; Blue Health Connection; Blue Health Assessment; Customer eServices; national provider directory; care management programs; services for deaf and hearing impaired; web accessibility for the visually impaired; travel benefit/services overseas; Healthy Families and Healthy Kids Programs; and *WalkingWorks*® Wellness Program		104-106
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $5,000 (PPO) or $7,000 (PPO/Non-PPO) per contract per year; some costs do not count toward this protection	22-23

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan
Basic Option – 2011

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 15. There is no deductible for Basic Option.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: Nothing for preventive care; $25 per office visit for primary care physicians and other health care professionals; $35 per office visit for specialists Non-PPO: You pay all charges	30-31
Services provided by a hospital:		
• Inpatient	PPO: $150 per admission up to $750 per admission Non-PPO: You pay all charges	68-70
• Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	71-74
Emergency benefits:		
• Accidental injury	PPO: $125 copayment for emergency room care; $50 copayment for urgent care Non-PPO: $125 copayment for emergency room care Ambulance transport services: $100 per day for ground ambulance; $150 per day for air or sea ambulance	80-81
• Medical emergency	Same as for accidental injury	80, 82-83
Mental health and substance abuse treatment	In-Network (PPO): Regular cost-sharing, such as $25 office visit copayment; $150 per day up to $750 per inpatient admission Out-of-Network (Non-PPO): You pay all charges	84-86
Prescription drugs	Retail Pharmacy Program: • PPO: $10/generic/$40 preferred brand-name per prescription/50% coinsurance ($50 maximum) for non-preferred brand-name drugs. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments. • Non-PPO: You pay all charges	87-97
Dental care	PPO: $25 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; $25 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	56, 98-99, 103
Special features: Flexible benefits option; Blue Health Connection; Blue Health Assessment; Customer eServices; national provider directory; care management programs; services for deaf and hearing impaired; web accessibility for the visually impaired; travel benefit/services overseas; Healthy Families and Healthy Kids Programs; and *WalkingWorks*® Wellness Program		104-106
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $5,000 (PPO) per contract per year; some costs do not count toward this protection	22-23

The *signs*
of a healthier Vermont

VERMONT
FREEDOM PLAN®

Non-Group ***Plan Options***

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

www.bcbsvt.com

The *signs*
of a healthier Vermont

We Give You Freedom to Choose Any Provider

We at Blue Cross and Blue Shield of Vermont believe strongly in the power of prevention, and to that end we cover preventive office visits at 100 percent when you use Preferred Providers, plus your first three primary care office visits have a low co-payment of only $15 per visit. Some plans restrict your choice of providers to only a few in each geographic area. But the Vermont Freedom Plan pays benefits for covered services provided by Preferred or Non-preferred providers. We have Preferred Providers nationwide and in foreign countries, thanks to contracting agreements through our sister Blue Cross and Blue Shield Plans. The local Blue Cross and Blue Shield plan determines which providers are Preferred. In Vermont, the Preferred network consists of the Plan's Participating Providers. In other states, however, it may include only a smaller group of providers who make special Preferred Provider Contracts with the local Plan. Although you have the freedom to choose which provider you see, we require you to call for prior approval before receiving certain services to be sure they're medically necessary. You'll find the list of these services on your Outline of Coverage. We also recommend that you call us before an inpatient admission to prevent unnecessary and non-covered stays.

To find out which providers are in the Preferred Provider Network in a given state, please consult a Preferred Provider directory for the region where you will seek service. To get a copy of a directory for a Plan in another state, call the BlueCard ACCESS Provider Locator at (800) 810-BLUE (2583) or visit **www.bluecares.com** on the Web.

If you use a Non-preferred Provider, we pay our Allowed Price and you must pay any balance between the Provider's charge and what we pay. You must also pay deductibles and coinsurance which may be higher for coverage of services by Non-preferred Providers. Certain providers must be Preferred in order for their services to be covered.

Those providers are:

- athletic trainers
- cardiac rehabilitation providers
- chiropractors
- home infusion therapy providers
- certified nurse midwives
- nutritional counseling providers
- physical rehabilitation facilities
- skilled nursing facilities

If you use one of these providers that is not in the Preferred Provider Network, you will be responsible for all charges for that care.

To enroll…

You may apply for Non-group coverage online at **www.bcbsvt.com** or complete the enclosed application and mail it to BCBSVT, PO Box 186, Montpelier, VT 05601-0186. When submitting your application for coverage, remember to include proof of prior insurance coverage if you or your family members were previously insured with another carrier. For adults age 19 and over, who do not have evidence of prior coverage, we will apply a one-year waiting period for any pre-existing condition.

Vermont Freedom Plan Options

The chart below gives a summary of the benefits under the Vermont Freedom Plan Non-group program. You'll see that there are two deductible options to choose from. Deductibles apply to most services, although you do not have to pay deductibles for many office visits. You pay your deductible once every calendar year, whether you use **Preferred** or **Non-preferred** Providers. Other payments you must make vary depending on the providers you use.

Deductible Options:	**Option A: $5,000 per member or $10,000 per family**		**Option B: $10,000 per member or $20,000 per family**	
	When you use **Preferred Providers**, you pay:	When you use **Non-preferred Providers**, you pay:	When you use **Preferred Providers**, you pay:	When you use **Non-preferred Providers**, you pay:
First three non-preventive primary care office visits	$15 co-payment	Deductible plus 40% coinsurance	$15 co-payment	Deductible plus 50% coinsurance
Non-preventive primary care office visits *(after first three)*, **Specialist office visits**	Deductible plus 20% coinsurance	Deductible plus 40% coinsurance	Deductible plus 30% coinsurance	Deductible plus 50% coinsurance
Preventive care	100%, not subject to deductible	Deductible plus 40% coinsurance	100%, not subject to deductible	Deductible plus 50% coinsurance
Inpatient general hospital services	Deductible plus 20% coinsurance	Deductible plus 40% coinsurance	Deductible plus 30% coinsurance	Deductible plus 50% coinsurance
Outpatient general hospital services	Deductible plus 20% coinsurance	Deductible plus 40% coinsurance	Deductible plus 30% coinsurance	Deductible plus 50% coinsurance
Emergency room services	Deductible plus 20% coinsurance	Deductible plus 20% coinsurance	Deductible plus 30% coinsurance	Deductible plus 30% coinsurance
Ambulance services	Deductible plus 20% coinsurance	Deductible plus 20% coinsurance	Deductible plus 30% coinsurance	Deductible plus 30% coinsurance
Private duty nursing *($2,000/year limit)*	Deductible plus 20% coinsurance	Deductible plus 40% coinsurance	Deductible plus 30% coinsurance	Deductible plus 50% coinsurance
Durable medical equipment	Deductible plus 20% coinsurance	Deductible plus 40% coinsurance	Deductible plus 30% coinsurance	Deductible plus 50% coinsurance
Home care	Deductible plus 20% coinsurance	Deductible plus 40% coinsurance	Deductible plus 30% coinsurance	Deductible plus 50% coinsurance
Out-of-pocket maximums *(After you pay this amount in one calendar year, BCBSVT covers services at 100% for the rest of the year)*	**Medical:** $6,000 plus applicable deductible	**Medical:** $9,000 plus applicable deductible	**Medical:** $13,500 plus applicable deductible	**Medical:** $13,500 plus applicable deductible
	When you use **Network** Providers, you pay:	When you use **Non-network** Providers, you pay:	When you use **Network** Providers, you pay:	When you use **Non-network** Providers, you pay:
Office visits for mental health and substance abuse services	Deductible plus 20% coinsurance	Deductible plus 40% coinsurance	Deductible plus 30% coinsurance	Deductible plus 50% coinsurance
Inpatient mental health and substance abuse treatment services	Deductible plus 20% coinsurance	Deductible plus 40% coinsurance	Deductible plus 30% coinsurance	Deductible plus 50% coinsurance
Prescription drugs	▪ **$275** separate deductible, then ▪ **$12.50** for each generic prescription, ▪ **50%** for each prescription on our Preferred Brand-name drug list, or ▪ **60%** for each Non-preferred prescription, with an out-of-pocket limit of $5,000 in a calendar year.	No coverage	▪ **$300** separate deductible, then ▪ **$15** for each generic prescription, ▪ **50%** for each prescription on our Preferred Brand-name drug list, or ▪ **60%** for each Non-preferred prescription, with an out-of-pocket limit of $5,000 in a calendar year.	No coverage
Lifetime maximum	None	None	None	None

This is only a partial listing of benefits. Please consult a subscriber contract for complete benefit details. The deductible for Preferred Providers and Non-preferred Providers is combined.

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Contact Us

Individual Products Service Center
(800) 625-6406

P.O. Box 186
Montpelier, VT 05601-0186
www.bcbsvt.com

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

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Healthcare Coverage

For Individuals and Families in Washington

PREMERA BLUE CROSS

This plan is "non-grandfathered" under federal healthcare reform legislation.

Deductible, coinsurance and copay represent what you pay. Benefits apply after calendar year deductible is met, unless otherwise noted.

MEDICAL BENEFITS PCY = Per Calendar Year	HERITAGE PREFERRED PLUS 30	
	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible per individual PCY	$1,000	Shared with in-network deductible
Coinsurance	30%	50%
Annual Coinsurance Maximum[2] PCY	$3,000	Unlimited
Calendar Year Maximum	$2 Million	
COVERED SERVICES		
PREVENTIVE CARE		
Preventive Care Exam	Covered in full[3]	Not covered
Immunizations		Preventive not covered; Seasonal covered in full[3]
Preventive Screenings (including mammography, PAP smears, PSA testing, colonoscopies and cholesterol screening)[4]	Covered in full[3]	50%
PROFESSIONAL CARE		
Office Visit Including Urgent Care	30%	50%
Other Outpatient Professional Services		
Inpatient Professional Services		
PHARMACY		
Retail and Mail Order $5,000 PCY (separate annual deductible applies; prescriptions limited to 30-day supply)	After $500 prescription drug deductible, member pays: Tier 1 = 20% (generic drugs); Tier 2 = 30% (preferred brand-name drugs); Tier 3 = 50% (non-preferred-brand-name drugs)	
VISION		
Routine Vision Exam	Covered in Full[3] (one exam per 2 calendar years)	
Vision Hardware (frames, lenses and contacts)	Covered in Full[3] ($200 per 2 calendar years)	
DIAGNOSTIC SERVICES		
Diagnostic X-ray and Laboratory Services	30%	50%
FACILITY CARE		
Inpatient Facility	30%	50%
Outpatient Surgery Facility		
Skilled Nursing Facility	30% (20 days PCY)	50% (limit shared with in-network)
EMERGENCY CARE		
Emergency Care (copay waived if direct admit to an inpatient facility)	$100 Copay plus 30%	
Ambulance Transportation	30% ($5,000 PCY)	
OTHER SERVICES		
Maternity Care including prenatal care	30%	50%
Spinal and Other Manipulations	30% (12 visits PCY)	50% (limit shared with in-network)
Acupuncture		
Supplies, Equipment and Prosthetics	30%	
Home Health Care	30% (130 Home Health visits PCY)	
Hospice Care (6-month maximum)	30% (Inpatient: 10 days max; Respite: 240 hrs. max)	
Rehabilitation (including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab; and Chronic Pain.)	30%(Outpatient: 15 visits PCY; Inpatient: 10 days PCY)	
Transplants (Organ & Bone Marrow) 12-month waiting period	30%	Not covered
Mental Health—Outpatient		50%
Mental Health—Inpatient		

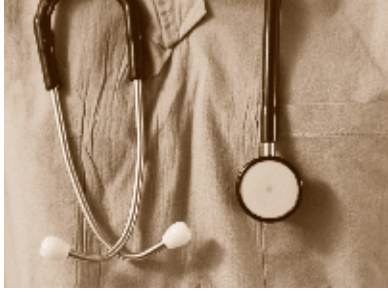
[1] Family deductible = 3x Individual

[2] After the coinsurance maximum is met, in-network providers are covered in full.

[3] Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

[4] A full list of preventive screenings, tests and other preventive services, is available on **premera. com**. You can receive these preventive services covered in full if you use preferred providers and are within the frequency, age, risk and gender guidelines outlined in the list.

Note: All coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracted with Premera Blue Cross.



Expansive provider networks

This plan offers you access to statewide and nationwide networks that offer valuable discounts on billed charges—so you can save money.

Our Heritage network includes thousands of doctors, hospitals and other healthcare providers throughout the state, including rural areas.

When you travel outside Washington, you can use a nationwide network of Blue Cross Blue Shield-contracted providers that are part of the BlueCard® Program.

Extras! Discounts for Members

We've negotiated special discounts up to **60% off** on health and wellness products and services not covered by your health plan. **To learn more, visit premera.com/discounts**.

Eligibility

You must be a resident of the state of Washington and not eligible for Medicare to apply. Please refer to the application for additional eligibility requirements.

To enroll in a Premera Blue Cross Individual health plan:

1. Review the following summary of benefits.
2. Review the separate rate sheet for your plan selection to determine your monthly rate.
3. Complete the Enrollment Application.
4. Complete the Standard Health Questionnaire for Washington state for each family member you wish to enroll.
5. Sign, date and return all of the information in the enclosed return envelope.

Approved applications postmarked or received by the 14th day of the month will be effective on the 15th of that month. A prorated subscription charge will apply for the partial month of coverage. Approved applications postmarked or received between the 15th and the last day of the month will be effective on the first day of the following month.

We're here. We're with you.

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association
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What is not covered

Benefits are not provided for treatment, surgery, services, drugs, or supplies for any of the following:

- Learning disorders
- Neurodevelopmental disabilities
- Chemical dependency
- Infertility
- Sexual dysfunction
- Sterilization or its reversal
- Obesity/morbid obesity, including food and exercise programs
- Cosmetic or reconstructive surgery (except as specifically provided)
- Dental services (except as specifically provided)
- Hearing examinations or hardware
- Temporomandibular joint disorder (TMJ)
- Orthognathic surgery
- Services payable by other types of insurance coverage
- Experimental or investigative services
- Over-the-counter or non-prescription drugs
- Services in excess of specified benefit maximums
- Services received when you are not covered by this program

This is only a summary of the major benefits provided by our plans. It is not a contract.

Contact your Premera Blue Cross producer today for more information or for help with enrollment.

Or, call us direct at 800-752-6663.

TDD/TTY for the hearing impaired:
800-842-5357

7001 220th St. S.W., Mountlake Terrace, WA 98043-2124

Mailing Address: P.O. Box 327, Seattle, WA 98111-0327