



Understanding The Coverage You Need

Providing the keys for learning and understanding
your coverage.



**BlueCross
BlueShield
of Kansas**

bcbsks.com

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Blue Cross and Blue Shield of Kansas is here to help you as more components of health care reform law become effective. We've produced this information to help you keep up-to-date and guide you through the disclosure process of the Summary of Benefits and Coverage and Uniform Glossary.

Standardized, consumer-friendly forms

As part of the Affordable Care Act, the federal government requires group health plans and health insurance issuers offering group and individual coverage to provide consumers two key documents. These documents provide consumers information needed to compare coverage options in different types of plans. This requirement applies to fully insured and self-insured group health plans regardless of grandfathered status.

- **Summary of Benefits and Coverage** – The SBC summarizes the key features of a health plan, such as the covered benefits, cost-sharing provisions and coverage limitations. SBCs include a new, standardized plan comparison tool called “coverage examples,” similar to the Nutrition Facts label required for packaged foods.
- **Uniform Glossary** – This glossary of terms written in plain language, helps consumers understand some of the most common but confusing jargon used in health insurance.

The SBC is not a guideline or example. It must be replicated using the exact wording, format and layout as set forth by the U.S. Department of Health and Human Services. Both of these forms are the direct result of model forms created through a public process led by the National Association of Insurance Commissioners (NAIC) and several representatives of insurers, health care professionals, consumer advocacy groups and others.

BlueCare Simple Bronze Choice
Coverage Period: Beginning on or after 1/1/2017
Plan Type: PPO

Summary of Benefits and Coverage: What This Plan Covers & What You Pay for Covered Services

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbks.com/bluecross or call 1-800-432-3990. For general definitions of common terms, such as allowed network, balance billing, coinsurance, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bcbks.com/bluecross or call 1-800-432-3990 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$6,500 person/\$13,000 family for In-Network. \$13,000 person/\$26,000 family for Out-of-Network. Doesn't apply to In-Network preventive care.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care.	For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$6,500 person/\$13,000 family for In-Network only. \$13,000 person/\$26,000 family for Out-of-Network only.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit, until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbks.com/providerdirectory or call 1-800-432-3990 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Questions: Call 1-800-432-3990 or visit us at www.bcbks.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.bcbks.com/bluecross or call 1-800-432-3990 to request a copy.

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Glossary of Health Coverage and Medical Terms

This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.) (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

For an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real-world case, see the coverage example in your Summary of Benefits and Coverage.

When a provider bills you for a benefit or payment (either in whole or in part), you may see an out-of-pocket limit. This limit indicates a term defined in this Glossary.

Balance Billing
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining amount of \$90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim
Request for a benefit (including reimbursement of a health care expense) made by you or your health insurer to your health insurer or plan for items or services you think are covered.

Cost-Sharing Reduction
Discounts that reduce the cost of care a plan doesn't cover usually for services covered by the plan.

Complications of Pregnancy
Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and emergency caesarean section generally aren't complications of pregnancy.

Copayment
A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the health care service. The amount can vary by the type of covered health care service.

Cost-Sharing
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child must pay out of your own pocket. Other costs, such as your premiums, penalties you may have to pay, and cost of care a plan doesn't cover usually aren't cost sharing.

Coinsurance
A percentage of the cost of care a plan doesn't cover usually for services covered by the plan.

Deductible
The amount you must pay for covered services before your plan begins to pay.

Out-of-Pocket Limit
The most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit, until the overall family out-of-pocket limit has been met.

Provider Network
A group of health care providers that a plan contracts with to provide services to its members. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).

Referral
A request from a primary care provider for you to see a specialist.

Specialist
A health care provider who is not a generalist.

Underlying Cause of Death
The primary cause of death that is listed on a death certificate.

Well-Child Visit
A preventive care service for children that includes a physical exam, growth and development assessment, and immunizations.

Well-Adult Visit
A preventive care service for adults that includes a physical exam, blood pressure, cholesterol, and blood sugar testing, and immunizations.

Time frames for delivery of SBCs

There are different time frames in place involving SBC distribution, depending on when enrollment occurs.

Time frames for Blue Cross and Blue Shield of Kansas providing SBCs to group	
New business	No later than seven business days after receipt of application. The SBC must be distributed by the first day of coverage IF information in the SBC has changed between the time the group applies for coverage and the first day of coverage.
At renewal	No later than when renewal materials are distributed
Upon request	No later than seven business days after the request

Time frames for group providing SBCs to employees and dependents	
Initial enrollment	<p>SBC should be sent with enrollment application materials.</p> <p>If application materials are not provided for enrollment, each employee and dependent must be provided an SBC no later than the first date of enrollment eligibility.</p> <p>If SBC information changes between the time the group applies for coverage and the first day of coverage, each employee must be provided an updated SBC by first day of coverage.</p>
Renewal	SBC should be provided when renewal materials are delivered no later than 30 days prior to the group's renewal date.
Special enrollment	Provide SBC within 90 days of enrollment.
Upon request	Provide SBC no later than seven business days after the request.

Paper and electronic SBCs

SBCs may be provided in either paper or electronic format.

- The SBCs can be found on the secure section of our website after a member logs in at: bcbsks.com/blueaccess
- The Uniform Glossary can be found at: bcbsks.com/sbcglossary

Consumers can also find the glossary on these government websites:

- healthcare.gov
- cciio.cms.gov
- dol.gov/ebsa/healthreform



Delivering the SBCs

Blue Cross and Blue Shield of Kansas will prepare and provide the SBCs to plan administrators. Groups are responsible for distributing the documents to their employees and dependents.

SBCs for dependents

You may provide one copy of the SBC to an employee and dependents if they reside at the same address. If any dependents live at a different location, you must also send them an SBC.

Penalties for non-compliance

Group health plans and health insurance issuers willfully failing to provide required information will be subject to a fine of not more than \$1,000 for each such failure. Each failure to deliver the SBC to an individual constitutes a separate offense under the Affordable Care Act.

Trust in Blue

Through all the health care changes since 1942, Blue Cross and Blue Shield of Kansas continues our well-grounded tradition of providing proper guidance to policyholders that trust us with their health. Contact your local BCBSKS sales representative for any questions you might have concerning the Summary of Benefits Coverage and Uniform Glossary.