

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual/Family | Plan Type: PPO



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 the 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.bcbsks.com/blueaccess](http://www.bcbsks.com/blueaccess) or call 1-800-432-3990. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.bcbsks.com/blueaccess](http://www.bcbsks.com/blueaccess) or call 1-800-432-3990 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$1,300 person/\$2,600 family. Doesn't apply to In-Network preventive care.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes, preventive care.	For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No. There are no other specific <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Coinsurance is 20% to a max of \$2,600 person / \$5,200 family. Total out of pocket max is \$3,900 person / \$7,800 family. 20% non PPO penalty applies annually up to \$2,000 person / \$4,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.bcbsks.com/providerdirectory">www.bcbsks.com/providerdirectory</a> or call 1-800-432-3990 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ).
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	<a href="#">Specialist</a> visit	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	<a href="#">Preventive care/screening</a> /immunization	\$0. Preventive is without cost share.	Deductible then 20% coinsurance	Immunizations as identified by the Center of Medicare And Medicaid Services.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsks.com">www.bcbsks.com</a>	Generic drugs	\$15 copay	\$15 copay	Generic drugs are mandatory if available.
	Preferred brand drugs	\$45 copay	\$45 copay	_____none_____
	Non-preferred brand drugs	\$45 copay	\$45 copay	_____none_____
	<a href="#">Specialty drugs</a>	Copay as applicable on the above three categories	Copay as applicable on the above three categories	_____none_____
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	<a href="#">Emergency medical transportation</a>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	<a href="#">Urgent care</a>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Same as office visit.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	Inpatient services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
<b>If you are pregnant</b>	Office visits	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	Childbirth/delivery professional services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	Childbirth/delivery facility services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$0. Home Health Care is without cost share.	\$0. Home Health Care is without cost share.	_____none_____
	<a href="#">Rehabilitation services</a>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	<a href="#">Habilitation services</a>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	<a href="#">Skilled nursing care</a>	\$0. Skilled Nursing Care is without cost share.	\$0. Skilled Nursing Care is without cost share.	_____none_____
	<a href="#">Durable medical equipment</a>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	<a href="#">Hospice services</a>	\$0. Hospice is without cost share.	\$0. Hospice is without cost share.	_____none_____
<b>If your child needs dental or eye care</b>	Children's eye exam	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Same as specialist visit unless vision screening for children under 5 years which is covered at 100% as preventative.
	Children's glasses	Not Covered	Not Covered	_____none_____
	Children's dental check-up	Not Covered	Not Covered	_____none_____

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## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Weight loss programs

### Other Covered Services (Limitation may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Infertility treatment
- Non-emergency care when traveling outside the U.S. See [www.bcbs.com/already-a-member/coverage-home-and-away.html](http://www.bcbs.com/already-a-member/coverage-home-and-away.html)
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Spinal manipulations

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Blue Cross and Blue Shield of Kansas Customer Service at 1-800-432-3990. You may also contact your state insurance department, Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit [www.ksinsurance.org](http://www.ksinsurance.org), or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Customer Service at 1-800-432-3990 or you can visit [www.bcbsks.com/blueaccess](http://www.bcbsks.com/blueaccess), or the Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit [www.ksinsurance.org](http://www.ksinsurance.org), or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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## Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Spanish (Español):	Para obtener asistencia en Español, llame al	1-800-432-3990
Tagalog (Tagalog):	Kung kailangan ninyo ang tulong sa Tagalog tumawag sa	1-800-432-3990
Chinese (中文):	如果需要中文的帮助，请拨打这个号码	1-800-432-3990
Navajo (Dine):	Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'	1-800-432-3990

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

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1300
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

#### This EXAMPLE event includes services like:

Specialist office visits (prenatal care)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (ultrasounds and blood work)  
 Specialist visit (anesthesia)

**Total Example Cost** \$12840

#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1300
Copayments	\$60
Coinsurance	\$2520
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3940</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1300
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)  
 Diagnostic tests (blood work)  
 Prescription drugs  
 Durable medical equipment (glucose meter)

**Total Example Cost** \$7460

#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1300
Copayments	\$1050
Coinsurance	\$585
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2990</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1300
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)  
 Diagnostic test (x-ray)  
 Durable medical equipment (crutches)  
 Rehabilitation services (physical therapy)

**Total Example Cost** \$2010

#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1300
Copayments	\$0
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1685</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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