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 <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 or call 1-800-432-3990. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.bcbsks.com/blueaccess or call 1-800-432-3990 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$650 person/ \$1,300 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 deductible?	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles 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</u> <u>limit</u> for this <u>plan</u> ?	Coinsurance is 20% to a max of \$1,300 person / \$2,600 family. Total out of pocket max is \$1,950 person / \$3,900 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 out-of-pocket limit?	Copayments for certain services, 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 <u>network provider</u> ?	Yes. See www.bcbsks.com /providerdirectory or call 1-800-432-3990 for a list of network providers.	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> .

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

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OMB Control Numbers 1545-2229, 1210-0147, and 0938 -1146 Released on April 6, 2016

0	Services You May Need	What You Will Pay		Limitediana Francisco 9 Other Language	
Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
If you visit a health care provider's office or clinic	Specialist visit	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
	Preventive care/screening/immunization	\$0. Preventive is without cost share.	Deductible then 20% coinsurance	Immunizations as identified by the Center of Medicare And Medicaid Services.	
If you have a teet	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
If you have a test	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
If you need drugs to treat	Generic drugs	\$15 copay	\$15 copay	Generic drugs are mandatory if available.	
your illness or condition	Preferred brand drugs	\$45 copay	\$45 copay	none	
More information about	Non-preferred brand drugs	\$45 copay	\$45 copay	none	
prescription drug coverage is available at www.bcbsks.com	Specialty drugs	Copay as applicable on the above three categories	Copay as applicable on the above three categories	none	
If you have outpatient surgery	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	
If you need immediate medical attention	Emergency room care	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
	Urgent care	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Same as office visit.	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	

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	Services You May Need	What You Will Pay			
Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have a hospital stay	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
If you need mental health,	Outpatient services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
behavioral health, or substance abuse services	Inpatient services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
If you are pregnant	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	
	Home health care	\$0. Home Health Care is without cost share.	\$0. Home Health Care is without cost share.	none	
	Rehabilitation services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
If you need help recovering or have other special health	Habilitation services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
needs	Skilled nursing care	\$0. Skilled Nursing Care is without cost share.	\$0. Skilled Nursing Care is without cost share.	none	
	Durable medical equipment	Deductible then 20% coinsurance	Deductible then 20% coinsurance	none	
	Hospice services	\$0. Hospice is without cost share.	\$0. Hospice is without cost share.	none	
If your child needs dental or eye care	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:

Routine eye care (Adult)

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 Hearing aids Hearing aids Cosmetic surgery 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

Routine foot care

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, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or 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 or call 1-800-318-2596.

Spinal manipulations

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

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

About these Coverage Examples:



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

Peg is Having a Bab (9 months of in-network pre-nata hospital delivery)		Managing Joe's type 2 Dia (a year of routine in-network care controlled condition)		Mia's Simple Fracture (in-network emergency room visit up care)	
 The plan's overall deductible Specialist coinsurance Hospital (facility) coinsurance 	\$650 20% 20%	 The plan's overall deductible Specialist coinsurance Hospital (facility) coinsurance 	\$650 20% 20%	 The plan's overall deductible Specialist coinsurance Hospital (facility) coinsurance 	\$650 20% 20%
Other <u>coinsurance</u>	20%	Other <u>coinsurance</u>	20%	Other <u>coinsurance</u>	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)		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)		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	\$12840	Total Example Cost	\$7460	Total Example Cost	\$2010
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$650	Deductibles	\$650	Deductibles	\$650
Copayments	\$0	Copayments	\$780	Copayments	\$0
Coinsurance	\$1300	Coinsurance	\$520	Coinsurance	\$385
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$55	Limits or exclusions	\$0
The total Peg would pay is	\$2010	The total Joe would pay is	\$2005	The total Mia would pay is	\$1035

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

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