

**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:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$1,000</b> person / <b>\$2,000</b> family. Doesn't apply to In-Network preventive care.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, preventive care.	For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No. There are no other specific <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Coinsurance is 30% to a max of <b>\$2,000</b> person / <b>\$4,000</b> family. Total out of pocket max is <b>\$6,350</b> person / <b>\$12,700</b> family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. 20% non PPO penalty applies annually up to <b>\$2,000</b> person / <b>\$4,000</b> family.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.bcbsks.com/providerdirectory">www.bcbsks.com/providerdirectory</a> or call 1-800-432-3990 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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

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 <a href="#">provider's office or clinic</a></b>	Primary care visit to treat an injury or illness	\$30 copay/visit	\$30 copay/visit	Telemedicine: Office visits provided via Telemedicine will be paid at 100% of the allowable charge. All other services provided via Telemedicine are subject to the same Cost Sharing Provisions as a Non-Telemedicine service.	
	<a href="#">Specialist</a> visit	\$30 copay/visit	\$30 copay/visit	—————none—————	
	<a href="#">Preventive care/screening/immunization</a>	\$0. Preventive is without cost share.	Deductible then 30% 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)	\$0 up to \$300 person, deductible then 30% coinsurance	\$0 up to \$300 person, deductible then 30% coinsurance	—————none—————	
	Imaging (CT/PET scans, MRIs)	\$0 up to \$300 person, deductible then 30% coinsurance	\$0 up to \$300 person, deductible then 30% coinsurance	—————none—————	
<b>If you need drugs to treat your illness or condition</b>	Tier 1	\$15 copay	\$15 copay	Generic drugs are mandatory if available.	
	Tier 2	\$40 copay	\$40 copay	—————none—————	
	Tier 3	\$60 copay	\$60 copay	—————none—————	
	More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsks.com">www.bcbsks.com</a>	<a href="#">Tier 4*</a>	Preferred: \$150 copay	Copay as applicable on the above three categories	—————none—————
	<a href="#">Tier 5*</a>	Non-preferred: 20% coinsurance not to exceed \$250			
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————	
	Physician/surgeon fees	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————	

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.bcbsks.com](http://www.bcbsks.com).]

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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 need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 copay then deductible and 30% coinsurance	\$200 copay then deductible and 30% coinsurance	—————none—————
	<a href="#">Emergency medical transportation</a>	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————
	<a href="#">Urgent care</a>	Copay is applicable to the provider type	Copay is applicable to the provider type	Same as office visit. For emergency services, out-of-network is subject to the in-network benefits.
<b>If you have a hospital stay*</b>	Facility fee (e.g., hospital room)	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————
	Physician/surgeon fees	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 copay/visit, other outpatient services subject to deductible then 30% coinsurance	\$30 copay/visit, other outpatient services subject to deductible then 30% coinsurance	—————none—————
	Inpatient services*	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————
<b>If you are pregnant</b>	Office visits	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————
	Childbirth/delivery professional services	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————
	Childbirth/delivery facility services	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care*</a>	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————
	<a href="#">Rehabilitation services</a>	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————
	<a href="#">Habilitation services</a>	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————
	<a href="#">Skilled nursing care*</a>	Deductible then 30% coinsurance	Deductible then 30% coinsurance	—————none—————

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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)	
If you need help recovering or have other special health needs	<a href="#">Durable medical equipment</a>	Deductible then 30% coinsurance	Deductible then 30% coinsurance	_____none_____
	<a href="#">Hospice services*</a>	Deductible then 30% coinsurance	Deductible then 30% coinsurance	_____none_____
If your child needs dental or eye care	Children's eye exam	Copay is applicable to the provider type	Copay is applicable to the provider type	Vision screening for children under 5 years 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

### 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
- Weight loss programs

**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, 1300 SW Arrowhead Road, Topeka, Kansas 66604, Phone: 1-800-432-2484, or visit [insurance.kansas.gov](http://insurance.kansas.gov), 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, 1300 SW Arrowhead Road, Topeka, Kansas 66604, Phone: 1-800-432-2484, or visit [insurance.kansas.gov](http://insurance.kansas.gov), 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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### 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](#).

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## 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, kwijjigo holne'	1-800-432-3990

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

**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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$3,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,570</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

**This EXAMPLE event includes services like:**

[Primary care physician](#) office visits (including disease education)  
[Diagnostic tests](#) (blood work)  
[Prescription drugs](#)  
[Durable medical equipment](#)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,980</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,600</b>

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

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