

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 or call 1-800-332-0307. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other **bolded** terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-326-2088 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	Network : \$800 individual / \$1,600 family. Non Network : \$800 per Individual / \$1,600 per Family. Doesn't apply to 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 with Network providers.	You will have to meet the deductible before the plan pays for any services. This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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 ?	Medical and Pharmacy combined Out of Pocket : Network : \$5,250 Ind. / \$10,500 Family. Non Network : \$5,250 Ind. / \$10,500 Family Network and Non Network accumulators apply separately.	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 limits 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. For a list of preferred providers, see www.bcbsks.com or call 1-800-332-0307.	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 a Non 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). Be aware, your Network provider might use a Non Network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

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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)	Non Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copayment / visit	Deductible plus 50% coinsurance	
	Specialist visit	\$40 copayment / visit	Deductible plus 50% coinsurance	
	Preventive care/screening /immunization	\$0 copayment	Deductible plus 50% coinsurance	Breast Cancer Screenings (Mammograms, Ultrasounds, and MRI's) and Pap Smears - Not limited to once per year / Network 100% regardless of diagnosis. Immunizations with Non Network providers covered in full up to age 6 only. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Covered lab services paid at 100% when using preferred labs (Quest, Stormont Vail, and The University of Kansas Health System).
	Imaging (CT/PET scans, MRIs)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
If you need drugs to treat your illness or condition <u>Prescription drug coverage</u> is administered by Caremark More information about <u>Prescription drug coverage</u> is available at www.caremark.com	Generic drugs	20% coinsurance (retail or mail order)	20% coinsurance on the plans allowed charge	First fill is a 30 day supply at retail and mail. A 90 day supply is allowed at retail and mail for subsequent refills.
	Preferred brand drugs	35% coinsurance (retail or mail order)	35% coinsurance on the plans allowed charge	Diabetic and Asthma medications that are considered Generic or Preferred brand with the following copays: Generic 10% coinsurance with a \$20 maximum per 30 day supply. Preferred brand: 20% coinsurance with a \$40 maximum per 30 day supply. Contraceptives: Covered with 0% member coinsurance.
	Non-preferred brand drugs	60% coinsurance (retail or mail order)	60% coinsurance on the plans allowed charge	Non Preferred Contraceptives : Covered subject to 65% coinsurance. Compound Medications covered only at a Network Pharmacy.

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

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		Network Provider (You will pay the least)	Non Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Specialty drugs*	30% coinsurance (with a \$100 maximum) per 30 day supply.	--none--	All fills must be filled through CVS Caremark Specialty (1-800-294-6324).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
	Physician/surgeon fees	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
If you need immediate medical attention	Emergency room care	\$100 copay plus deductible and 20% coinsurance	\$100 copay plus deductible and 20% coinsurance	Must meet emergency criteria. Copay waived if admitted within 24 hours.
	Emergency medical transportation	Deductible plus 20% coinsurance	Deductible plus 20% coinsurance	Must meet emergency criteria.
	Urgent care	\$50 copayment / visit	Deductible plus 50% coinsurance	
If you have a hospital stay*	Facility fee (e.g., hospital room)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
	Physician/surgeon fees	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copayment for specialty physician	Deductible plus 50% coinsurance	\$20 copayment for group therapy sessions.
	Inpatient services or Residential Treatment Facilities*	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required for inpatient services or Residential Treatment Facilities. For help call Lucet at 1-800-952-5906.
If you are pregnant	Office visits	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Medical necessity is required for stays longer than 48/96 hours.
	Childbirth/delivery professional services	Deductible then 20% coinsurance	Deductible plus 50% coinsurance	Medical necessity is required for stays longer than 48/96 hours.

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		Network Provider (You will pay the least)	Non Network Provider (You will pay the most)	
If you are pregnant	Childbirth/delivery facility services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Medical necessity is required for stays longer than 48/96 hours.
If you need help recovering or have other special health needs	Home health care*	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization may be required.
	Rehabilitation services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization required.
	Habilitation services	Not covered	Not covered	Unless under Autism rider of the policy.
	Skilled nursing care*	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
	Durable medical equipment	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior Authorization may be required by the TPA.
	Hospice services*	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior Authorization may be required. Inpatient Hospice care limited to 6 months.
If your child needs dental or eye care	Children's eye exam	\$0 copayment for first annual visit, then \$60 copayment per visit	Deductible plus 50% coinsurance	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered under Medical Plan	Not covered under Medical Plan	

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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
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Private-duty nursing
- Dental care (Adult)
- Routine foot care

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

- Bariatric surgery
- Non-emergency care when traveling outside the U.S. See www.bcbs.com/already-a-member/coverage-home-and-away.html
- Hearing aids - \$5,000 maximum/3 years
- Routine eye care (Adult)
- Infertility treatment
- Chiropractic 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, 1300 SW Arrowhead Road, Topeka, Kansas 66604, Phone: 1-800-432-2484, or visit insurance.kansas.gov, 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.

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, or the Kansas Insurance Department, 1300 SW Arrowhead Road, Topeka, Kansas 66604, Phone: 1-800-432-2484, or visit insurance.kansas.gov, 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

[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, kwijigo 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 Network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine Network care of a well-controlled condition)		Mia's Simple Fracture (Network emergency room visit and follow up care)	
■ The plan's overall deductible	\$800	■ The plan's overall deductible	\$800	■ The plan's overall deductible	\$800
■ Specialist copayment	\$40	■ Specialist copayment	\$40	■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%	■ Other coinsurance	20%	■ Other coinsurance	20%
This EXAMPLE event includes services like:		This EXAMPLE event includes services like:		This EXAMPLE event includes services like:	
Specialist office visits (prenatal care)		Primary care physician office visits (including disease education)		Emergency room care (including medical supplies)	
Childbirth/Delivery Professional Services		Diagnostic tests (blood work)		Diagnostic test (x-ray)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (crutches)	
Diagnostic tests (ultrasounds and blood work)		Durable medical equipment		Rehabilitation services (physical therapy)	
Specialist visit (anesthesia)					
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
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	\$800	Deductibles	\$800	Deductibles	\$800
Copayments	\$0	Copayments	\$200	Copayments	\$200
Coinsurance	\$2,400	Coinsurance	\$80	Coinsurance	\$300
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$70	Limits or exclusions	\$3,500	Limits or exclusions	\$10
The total Peg would pay is	\$3,270	The total Joe would pay is	\$4,580	The total Mia would pay is	\$1,310

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

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