

**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 <a href="#">deductible</a> ?                                | <b>\$1,000</b> person / <b>\$2,000</b> family for In-Network. <b>\$4,000</b> person / <b>\$8,000</b> family for Out-of-Network. 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> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | 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> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | No. There are no other specific <a href="#">deductibles</a> .  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <b>\$7,100</b> person / <b>\$14,200</b> family for In-Network only. <b>\$10,600</b> person / <b>\$21,200</b> family for Out-of-Network only.                                 | 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.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.   | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | 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. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |

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 All [copayment](#) costs shown in this chart are before your [deductible](#) has been met, and all [coinsurance](#) costs 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<br>(You will pay the least)            | Out-of-Network Provider<br>(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        | \$25 copay/visit  | Deductible then 50% coinsurance                    | 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                        | \$50 copay/visit  | Deductible then 50% coinsurance                    | —————none—————   |
|   | <a href="#">Preventive care/screening</a> /immunization | \$0. Preventive is without cost share.                  | Deductible then 50% coinsurance                    | Immunizations as identified by the Center of Medicare and Medicaid Services. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if these services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| <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 | Deductible then 50% coinsurance                    | —————none—————   |
|   | Imaging (CT/PET scans, MRIs)                            | \$0 up to \$300 person, deductible then 30% coinsurance | Deductible then 50% coinsurance                    | —————none—————   |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsks.com">www.bcbsks.com</a> | Tier 1 (Generic Preferred)                              | \$10 copay  | Deductible then 50% coinsurance                    | Copay applies until Maximum Out-of-Pocket is met. Generic drugs are mandatory if available unless physician prescribes a brand drug.   |
|   | Tier 2 (Generic Non-Preferred)                          | \$30 copay  | Deductible then 50% coinsurance                    | Copay applies until Maximum Out-of-Pocket is met.  |
|   | Tier 3 (Brand Preferred)                                | \$65 copay  | Deductible then 50% coinsurance                    | Copay applies until Maximum Out-of-Pocket is met.  |
|   | Tier 4 (Brand Non-Preferred)                            | \$100 copay   | Deductible then 50% coinsurance                    | Copay applies until Maximum Out-of-Pocket is met.  |

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| Common Medical Event  | Services You May Need                             | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|---|---|---|--|---|
|   |   | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you need drugs to treat your illness or condition</b><br><br>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 5* (Specialty Preferred)</a>     | Deductible then 25% coinsurance. The coinsurance amount will not exceed \$500 per prescription.                               | Deductible then 50% coinsurance                    | After deductible is met, coinsurance applies until Maximum Out-of-Pocket is met. If a Specialty Prescription Drug is obtained from a Pharmacy other than the Company's Designated Specialty Pharmacy, the drug will only be eligible for Out-of-Network benefits. |
|   | <a href="#">Tier 6* (Specialty Non-Preferred)</a> |   |  |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)    | Deductible then 30% coinsurance   | Deductible then 50% coinsurance                    | _____none_____  |
|   | Physician/surgeon fees                            | Deductible then 30% coinsurance   | Deductible then 50% coinsurance                    | _____none_____  |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>               | Deductible then 30% coinsurance   | Deductible then 30% coinsurance                    | _____none_____  |
|   | <a href="#">Emergency medical transportation</a>  | Deductible then 30% coinsurance   | Deductible then 30% coinsurance                    | _____none_____  |
|   | <a href="#">Urgent care</a>                       | \$25 copay/visit  | Deductible then 50% coinsurance                    | 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 50% coinsurance                    | _____none_____  |
|   | Physician/surgeon fees                            | Deductible then 30% coinsurance   | Deductible then 50% coinsurance                    | _____none_____  |
| <b>If you need mental health, behavioral health, or substance abuse services</b>  | Outpatient services                               | \$25 copay/visit. Emergency room, ambulance or urgent care services; please see applicable sections for coverage information. | Deductible then 50% coinsurance                    | _____none_____  |
|   | Inpatient services*                               | Deductible then 30% coinsurance   | Deductible then 50% coinsurance                    | _____none_____  |

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| Common Medical Event  | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | Network Provider<br>(You will pay the least)             | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you are pregnant</b>  | Office visits                             | Deductible then 30% coinsurance                          | Deductible then 50% coinsurance                    | Cost sharing does not apply for <a href="#">preventive services</a> .  |
|   | Childbirth/delivery professional services | Deductible then 30% coinsurance                          | Deductible then 50% coinsurance                    | _____none_____   |
|   | Childbirth/delivery facility services     | Deductible then 30% coinsurance                          | Deductible then 50% 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 50% coinsurance                    | _____none_____   |
|   | <a href="#">Rehabilitation services</a>   | Deductible then 30% coinsurance                          | Deductible then 50% coinsurance                    | Speech Therapy: Limited to 90 visits per Insured per benefit period.   |
|   | <a href="#">Habilitation services</a>     | Deductible then 30% coinsurance                          | Deductible then 50% coinsurance                    | _____none_____   |
|   | <a href="#">Skilled nursing care*</a>     | Deductible then 30% coinsurance                          | Deductible then 50% coinsurance                    | _____none_____   |
|   | <a href="#">Durable medical equipment</a> | Deductible then 30% coinsurance                          | Deductible then 50% coinsurance                    | _____none_____   |
|   | <a href="#">Hospice services*</a>         | Deductible then 30% coinsurance                          | Deductible then 50% coinsurance                    | _____none_____   |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | \$50 copay/visit   | Deductible then 50% coinsurance                    | Vision services are limited to Insureds through the benefit period in which they turn age 19. Screening for children under 5 years which is covered at 100% as Preventive.   |
|   | Children's glasses                        | Deductible then 30% coinsurance                          | Deductible then 50% coinsurance                    | Eyeglasses are limited to Insureds through the benefit period in which they turn age 19.   |
|   | Children's dental check-up                | \$0. Children's dental check-ups are without cost share. | Deductible then 50% coinsurance                    | Dental cleanings and periodic evaluations are covered at 100%. All other dental services are subject to deductible and/or coinsurance. Dental services are limited to Insureds through the benefit period in which they turn age 19. |

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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](#).)

- Abortion (except in the case when the life of the mother is endangered)
- 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 Department, of Insurance 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 Department of Insurance, 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](#).

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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 |

*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](#) **\$1,000**
- [Specialist copayment](#) **\$50**
- Hospital (facility) [coinsurance](#) **30%**
- Other [coinsurance](#) **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)

**Total Example Cost** **\$12,700**

**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 [plan's](#) overall [deductible](#) **\$1,000**
- [Specialist copayment](#) **\$50**
- Hospital (facility) [coinsurance](#) **30%**
- Other [coinsurance](#) **30%**

**This EXAMPLE event includes services like:**

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

**Total Example Cost** **\$5,600**

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

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$900          |
| <a href="#">Copayments</a>        | \$1,300        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,220</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) **\$1,000**
- [Specialist copayment](#) **\$50**
- Hospital (facility) [coinsurance](#) **30%**
- Other [coinsurance](#) **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)

**Total Example Cost** **\$2,800**

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

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,000        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$400          |
| <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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