

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 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 or call 1-800-432-3990 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$7,100 person / \$14,200 family for In-Network. \$13,600 person / \$27,200 family for Out-of-Network. Doesn't apply to In-Network 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.	For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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 ?	\$7,100 person / \$14,200 family for In-Network only. \$13,600 person / \$27,200 family for Out-of-Network only.	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. See www.bcbsks.com/providerdirectory or call 1-800-432-3990 for a list of network providers .	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 an out-of-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 an out-of-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)	Out-of-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	Deductible then \$0	Deductible then \$0	Telemedicine: Services provided via Telemedicine are subject to the same Cost Sharing provisions as a non-Telemedicine service.
	Specialist visit	Deductible then \$0	Deductible then \$0	—————none—————
	Preventive care/screening /immunization	\$0. Preventive is without cost share.	Deductible then \$0	Immunizations as identified by the Center of Medicare and Medicaid Services. 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 then \$0	Deductible then \$0	—————none—————
	Imaging (CT/PET scans, MRIs)	Deductible then \$0	Deductible then \$0	—————none—————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsks.com	Tier 1 (Generic Preferred)	Deductible then \$0	Deductible then \$0	Generic drugs are mandatory if available unless physician prescribes a brand drug.
	Tier 2 (Generic Non-Preferred)	Deductible then \$0	Deductible then \$0	—————none—————
	Tier 3 (Brand Preferred)	Deductible then \$0	Deductible then \$0	—————none—————
	Tier 4 (Brand Non-Preferred)	Deductible then \$0	Deductible then \$0	—————none—————
	Tier 5* (Specialty Preferred) Tier 6* (Specialty Non-Preferred)	Deductible then \$0	Deductible then \$0	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then \$0	Deductible then \$0	—————none—————
	Physician/surgeon fees	Deductible then \$0	Deductible then \$0	—————none—————
If you need immediate medical attention	Emergency room care	Deductible then \$0	Deductible then \$0	—————none—————
	Emergency medical transportation	Deductible then \$0	Deductible then \$0	—————none—————
	Urgent care	Deductible then \$0	Deductible then \$0	For emergency services, out-of-network is subject to the in-network benefits.

[* 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)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay*	Facility fee (e.g., hospital room)	Deductible then \$0	Deductible then \$0	_____none_____
	Physician/surgeon fees	Deductible then \$0	Deductible then \$0	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible then \$0. Emergency room, ambulance or urgent care services; please see applicable sections for coverage information.	Deductible then \$0	_____none_____
	Inpatient services*	Deductible then \$0	Deductible then \$0	_____none_____
If you are pregnant	Office visits	Deductible then \$0	Deductible then \$0	Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	Deductible then \$0	Deductible then \$0	_____none_____
	Childbirth/delivery facility services	Deductible then \$0	Deductible then \$0	_____none_____
If you need help recovering or have other special health needs	Home health care*	Deductible then \$0	Deductible then \$0	_____none_____
	Rehabilitation services	Deductible then \$0	Deductible then \$0	Speech Therapy: Limited to 90 visits per Insured per benefit period.
	Habilitation services	Deductible then \$0	Deductible then \$0	_____none_____
	Skilled nursing care*	Deductible then \$0	Deductible then \$0	_____none_____
	Durable medical equipment	Deductible then \$0	Deductible then \$0	_____none_____
	Hospice services*	Deductible then \$0	Deductible then \$0	_____none_____
If your child needs dental or eye care	Children's eye exam	Deductible then \$0	Deductible then \$0	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 \$0	Deductible then \$0	Eyeglasses are limited to Insureds through the benefit period in which they turn age 19.

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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 your child needs dental or eye care	Children's dental check-up	\$0. Children's dental check-ups are without cost share.	Deductible then \$0	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
- 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, 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 Department of Insurance, 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](#).

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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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$7,100	■ The plan's overall deductible	\$7,100	■ The plan's overall deductible	\$7,100
■ Specialist deductible	\$7,100	■ Specialist deductible	\$7,100	■ Specialist deductible	\$7,100
■ Hospital (facility) deductible	\$7,100	■ Hospital (facility) deductible	\$7,100	■ Hospital (facility) deductible	\$7,100
■ Other deductible	\$7,100	■ Other deductible	\$7,100	■ Other deductible	\$7,100
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		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	\$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	\$7,100	Deductibles	\$5,400	Deductibles	\$2,800
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$7,160	The total Joe would pay is	\$5,420	The total Mia would pay is	\$2,800

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

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