**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 https://www.bcbsks.com/sbcs-and-contracts 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.cciio.cms.gov or call 1-800-432-3990 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,500** person / **$3,000** family for In-Network. There is no coverage for Out-of-Network services. 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. | This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. 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?** | **$7,500** person / **$15,000** family for In-Network. There is no coverage for Out-of-Network services. | 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**. |

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 | $25 copay/visit (deductible does not apply) | Not Covered | 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. |
| | Specialist visit | $50 copay/visit (deductible does not apply) | Not Covered | ——————none—————— |
| | Preventive care/screening/immunization | $0 (deductible does not apply). Preventive is without cost share. | Not Covered | Immunizations as identified by the Centers for Medicare & Medicaid Services (CMS). 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) | 35% coinsurance | Not Covered | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 35% coinsurance | Not Covered | ——————none—————— |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.bcbsks.com | Tier 1 (Generic Preferred)<br><br>Tier 2 (Generic Non-Preferred) | $10 copay (deductible does not apply)<br><br>$30 copay (deductible does not apply) | Not Covered | Copay applies until Maximum Out-of-Pocket is met. Generic drugs are mandatory if available unless physician prescribes a brand drug. |
| | Tier 3 (Brand Preferred) | $65 copay (deductible does not apply) | Not Covered | Copay applies until Maximum Out-of-Pocket is met. |
| | Tier 4 (Brand Non-Preferred) | 45% coinsurance | Not Covered | After deductible is met, coinsurance applies until Maximum Out-of-Pocket is met. |

| 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 drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.bcbsks.com | Tier 5* (Specialty Preferred)<br><br>Tier 6* (Specialty Non-Preferred) | 50% coinsurance | Not Covered | After deductible is met, coinsurance applies until Maximum Out-of-Pocket is met. Specialty Drugs must be obtained from the Blue Cross and Blue Shield of Kansas Designated Specialty Pharmacy. If a Specialty Prescription Drug is obtained from a Pharmacy other than our Designated Specialty Pharmacy, the drug will not be eligible for benefits. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 35% coinsurance | Not Covered | ——————none—————— |
| | Physician/surgeon fees | 35% coinsurance | Not Covered | ——————none—————— |
| **If you need immediate medical attention** | Emergency room care | $300 copay (deductible does not apply to copay), then 35% coinsurance | $300 copay (deductible does not apply to copay), then 35% coinsurance | ——————none—————— |
| | Emergency medical transportation | 35% coinsurance | 35% coinsurance | ——————none—————— |
| | Urgent care | $60 copay/visit (deductible does not apply) | Not Covered | For emergency services, out-of-network is subject to the in-network benefits. |
| **If you have a hospital stay*** | Facility fee (e.g., hospital room) | 35% coinsurance | Not Covered | ——————none—————— |
| | Physician/surgeon fees | 35% coinsurance | Not Covered | ——————none—————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/visit (deductible does not apply). Emergency room, ambulance or urgent care services; please see applicable sections for coverage information. | Not Covered | ——————none—————— |
| | Inpatient services* | 35% coinsurance | Not Covered | ——————none—————— |

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

| 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 are pregnant** | Office visits | 35% coinsurance | Not Covered | Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | 35% coinsurance | Not Covered | ——————none—————— |
| | Childbirth/delivery facility services | 35% coinsurance | Not Covered | ——————none—————— |
| **If you need help recovering or have other special health needs** | Home health care* | 35% coinsurance | Not Covered | ——————none—————— |
| | Rehabilitation services | 35% coinsurance | Not Covered | Speech Therapy: Limited to 90 visits per Insured per benefit period. |
| | Habilitation services | 35% coinsurance | Not Covered | ——————none—————— |
| | Skilled nursing care* | 35% coinsurance | Not Covered | ——————none—————— |
| | Durable medical equipment | 35% coinsurance | Not Covered | ——————none—————— |
| | Hospice services* | 35% coinsurance | Not Covered | ——————none—————— |
| **If your child needs dental or eye care** | Children's eye exam | $50 copay/visit (deductible does not apply) | Not Covered | 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 | 35% coinsurance | Not Covered | Eyeglasses are covered up to three sets of lenses and three pairs of frames per 365 days. Limited to Insureds through the benefit period in which they turn age 19. |
| | Children's dental check-up | $0 (deductible does not apply). Children's dental check-ups are without cost share. | Not Covered | 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. |

## 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
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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

- Infertility treatment
- Private-duty nursing
- 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 https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/. 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 on how 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.

**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?** **Not Applicable**
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.

[* For more information about limitations and exceptions, see the **plan** or policy document at **www.bcbsks.com**.]
**Questions:** Call **1-800-432-3990** or visit us at **www.bcbsks.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call **1-800-432-3990** to request a copy.

## 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 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 | $1,500 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 35% |
| Other coinsurance | 35% |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $10 |
| Coinsurance | $2,800 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,370** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 35% |
| Other coinsurance | 35% |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,100 |
| Copayments | $1,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,320** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 35% |
| Other coinsurance | 35% |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $300 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,000** |

The plan would be responsible for the other costs of these EXAMPLE covered services.