

## Summary of Benefits and Coverage: What this Plan Covers &amp; 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 deductible?	\$5,000 person / \$10,000 family. Doesn't apply to In-Network preventive care.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes, preventive care.	For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . 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 deductibles for specific services?	No. There are no other specific <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Deductible is \$5,000 person / \$10,000 family. Total out of pocket max is \$6,350 person / \$12,700 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. 20% non PPO penalty applies annually up to \$2,000 person/ \$4,000 family.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See <a href="http://www.bcbsks.com/providerdirectory">www.bcbsks.com/providerdirectory</a> or call 1-800-432-3990 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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 (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)



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.
	<a href="#">Specialist</a> visit	Deductible then \$0	Deductible then \$0	none
	<a href="#">Preventive care/screening</a> /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 <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsks.com">www.bcbsks.com</a>	Tier 1 (Generic)	Deductible then \$15 copay	Deductible then \$15 copay	Generic drugs are mandatory if available.
	Tier 2 (Brand Preferred)	Deductible then \$50 copay	Deductible then \$50 copay	none
	Tier 3 (Brand Non-Preferred)	Deductible then \$75 copay	Deductible then \$75 copay	none
	<a href="#">Tier 4* (Specialty Preferred)</a>	Preferred: Deductible then \$150 copay	Not Covered	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.
	<a href="#">Tier 5* (Specialty Non-Preferred)</a>	Non-Preferred: Deductible then 20% coinsurance not to exceed \$250		
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

[\* 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)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	Deductible then \$0	Deductible then \$0	none
	<a href="#">Emergency medical transportation</a>	Deductible then \$0	Deductible then \$0	none
	<a href="#">Urgent care</a>	Deductible then \$0	Deductible then \$0	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)	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. Emergency room, ambulance or urgent care services; please see applicable sections for coverage information.	none
	Inpatient services*	Deductible then \$0	Deductible then \$0	none
If you are pregnant	Office visits	Deductible then \$0	Deductible then \$0	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive</a> 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	<a href="#">Home health care*</a>	Deductible then \$0	Deductible then \$0	none
	<a href="#">Rehabilitation services</a>	Deductible then \$0	Deductible then \$0	none
	<a href="#">Habilitation services</a>	Deductible then \$0	Deductible then \$0	none
	<a href="#">Skilled nursing care*</a>	Deductible then \$0	Deductible then \$0	none
	<a href="#">Durable medical equipment</a>	Deductible then \$0	Deductible then \$0	none
	<a href="#">Hospice services*</a>	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 screening for children under 5 years is covered at 100% as preventative.
	Children's glasses	Not Covered	Not Covered	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 your child needs dental or eye care	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 <a href="http://www.bcbs.com/already-a-member/coverage-home-and-away.html">www.bcbs.com/already-a-member/coverage-home-and-away.html</a>	• 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](http://Marketplace). For more information about the [Marketplace](http://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](http://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](http://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 overall deductible</a>	\$5,000
■ <a href="#">Specialist deductible</a>	\$5,000
■ <a href="#">Hospital (facility) deductible</a>	\$5,000
■ <a href="#">Other deductible</a>	\$5,000

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	
<a href="#">Deductibles</a>	\$5,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,070</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's overall deductible</a>	\$5,000
■ <a href="#">Specialist deductible</a>	\$5,000
■ <a href="#">Hospital (facility) deductible</a>	\$5,000
■ <a href="#">Other deductible</a>	\$5,000

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	
<a href="#">Deductibles</a>	\$5,000
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,120</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's overall deductible</a>	\$5,000
■ <a href="#">Specialist deductible</a>	\$5,000
■ <a href="#">Hospital (facility) deductible</a>	\$5,000
■ <a href="#">Other deductible</a>	\$5,000

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	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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

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