

**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>\$3,500</b> person / <b>\$7,000</b> family. 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?	Yes. <b>\$100</b> person / <b>\$200</b> family for <a href="#">prescription drug coverage</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Coinsurance is 40% to a max of <b>\$2,000</b> person / <b>\$4,000</b> family. Total out of pocket max is <b>\$6,350</b> person / <b>\$12,700</b> family. 20% non PPO penalty applies annually up to <b>\$2,000</b> person / <b>\$4,000</b> family.	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](#) 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 copay/visit	\$30 copay/visit	5 visits per person covered at copay, then subject to deductible and coinsurance. The visit maximum (5 visit per person) is a combined maximum between primary and specialist office visits.
	<a href="#">Specialist</a> visit	\$60 copay/visit	\$60 copay/visit	5 visits per person covered at copay, then subject to deductible and coinsurance. The visit maximum (5 visit per person) is a combined maximum between primary and specialist office visits.
	<a href="#">Preventive care/screening</a> /immunization	\$0. Preventive is without cost share.	Deductible then 40% coinsurance	Immunizations as identified by the Center of Medicare and Medicaid Services.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Deductible then 40% coinsurance	Deductible then 40% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	Deductible then 40% coinsurance	Deductible then 40% coinsurance	—————none—————
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsks.com">www.bcbsks.com</a>	Generic drugs	\$15 copay	\$15 copay	—————none—————
	Preferred brand drugs	\$100 person / \$200 family deductible then 40% coinsurance with a minimum of \$30 or whichever is greater	\$100 person / \$200 family deductible then 40% coinsurance with a minimum of \$30 or whichever is greater	—————none—————
	Non-preferred brand drugs	\$100 person / \$200 family deductible then 60% coinsurance with a minimum of \$50 or whichever is greater	\$100 person / \$200 family deductible then 60% coinsurance with a minimum of \$50 or whichever is greater	—————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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsks.com">www.bcbsks.com</a></p>	<a href="#">Specialty drugs</a>	Your cost as applicable on the above three categories	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.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
	Physician/surgeon fees	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 copay then deductible and 40% coinsurance	\$250 copay then deductible and 40% coinsurance	_____none_____
	<a href="#">Emergency medical transportation</a>	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
	<a href="#">Urgent care</a>	Copay is applicable to the provider type	Copay is applicable to the provider type	Same as office visit.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
	Physician/surgeon fees	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 copay/visit, other outpatient services subject to deductible then 40% coinsurance	\$30 copay/visit, other outpatient services subject to deductible then 40% coinsurance	5 visits per person covered at copay, then subject to deductible and coinsurance. The visit maximum (5 visit per person) is a combined maximum between primary and specialist office visits.
	Inpatient services	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
<b>If you are pregnant</b>	Office visits	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____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)	
<b>If you are pregnant</b>	Childbirth/delivery professional services	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
	Childbirth/delivery facility services	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
	<a href="#">Rehabilitation services</a>	Deductible then 40% coinsurance	Deductible then 40% coinsurance	Subject to office visit copay based on specialty and visit limits: Outpatient Speech Therapy: 30 visits, Outpatient Rehab: 40 visits, Spinal Manipulations: 20 visits.
	<a href="#">Habilitation services</a>	Deductible then 40% coinsurance	Deductible then 40% coinsurance	Subject to office visit copay based on specialty and visit limits: Outpatient Speech Therapy: 30 visits, Outpatient Rehab: 40 visits, Spinal Manipulations: 20 visits.
	<a href="#">Skilled nursing care</a>	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
	<a href="#">Durable medical equipment</a>	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
	<a href="#">Hospice services</a>	Deductible then 40% coinsurance	Deductible then 40% coinsurance	_____none_____
<b>If your child needs dental or eye care</b>	Children's eye exam	Copay is applicable to the provider type	Copay is applicable to the provider type	Vision screening for children under 5 years is covered at 100% as preventative. All other copay and visit limitations are same as office visit.
	Children's glasses	Not Covered	Not Covered	_____none_____
	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
- Weight loss programs

### 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

**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: 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 Insurance Department, 1300 SW Arrowhead Road, Topeka, Kansas 66604, Phone: 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](#).

### 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, 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</a> overall <a href="#">deductible</a>	\$3,500
■ <a href="#">Specialist coinsurance</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

**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>	\$3,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,900

*What isn't covered*

Limits or exclusions \$60

**The total Peg would pay is** **\$6,460**

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,500
■ <a href="#">Specialist coinsurance</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

**This EXAMPLE event includes services like:**

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

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

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

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$1,200
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions \$20

**The total Joe would pay is** **\$2,020**

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,500
■ <a href="#">Specialist coinsurance</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

**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** **\$2,810**

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

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$2,800
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions \$0

**The total Mia would pay is** **\$2,810**

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

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

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