

**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.** Please read the State Employee Health Plan Summary Plan Description that contains the complete terms of this plan. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other bolded terms please call 1-800-332-0307.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network</a> : \$800 Individual / \$1,600 Family. <a href="#">Non-network</a> : \$800 per Individual / \$1,600 per Family. Doesn't apply to 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 with <a href="#">network</a> providers.	You will have to meet the <a href="#">deductible</a> before the plan pays for any services. This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
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> ?	Medical and Pharmacy combined <a href="#">out-of-pocket</a> : <a href="#">Network</a> : \$5,250 Ind. / \$10,500 Family <a href="#">Non-network</a> : \$5,250 Ind. / \$10,500 Family <a href="#">network</a> and <a href="#">non-network</a> accumulators apply separately.	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. For a list of preferred providers, see <a href="http://www.bcbsks.com">www.bcbsks.com</a> or call 1-800-332-0307.	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 a <a href="#">non-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 a <a href="#">non-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> .

Questions: Call 1-800-432-3990 or visit us at [www.bcbsks.com](http://www.bcbsks.com).

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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 provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 copayment / visit	Deductible plus 50% coinsurance	
	<a href="#">Specialist</a> visit	\$40 copayment / visit	Deductible plus 50% coinsurance	
	<a href="#">Preventive care/screening</a> /immunization	\$0 copayment	Deductible plus 50% coinsurance	Mammograms and Pap Smears - Not limited to once per year / in <a href="#">network</a> 100% regardless of diagnosis. Immunizations with <a href="#">non-network</a> providers covered in full up to age 6 only.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Lab services paid at 100% when using preferred labs (Quest, Stormont Vail, and The University of Kansas Hospital System).
	Imaging (CT/PET scans, MRIs)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
<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.caremark.com">www.caremark.com</a>	Generic drugs	20% coinsurance (retail or mail order)	20% coinsurance on the plans allowed charge	First fill is a 30 day supply at retail and mail. A 90 day supply is allowed at retail and mail for subsequent refills.
	Preferred brand drugs	35% coinsurance (retail or mail order)	35% coinsurance on the plans allowed charge	<b>Diabetic</b> and <b>Asthma</b> medications that are considered <b>Generic</b> or <b>Preferred</b> brand with the following copays: <b>Generic</b> 10% coinsurance with a \$20 maximum per 30 day supply. <b>Preferred</b> brand: 20% coinsurance with a \$40 maximum per 30 day supply. <b>Contraceptives</b> : Covered with 0% member coinsurance.
	Non-preferred brand drugs	60% coinsurance (retail or mail order)	60% coinsurance on the plans allowed charge	<b>Non-Preferred Contraceptives</b> : Covered subject to 65% coinsurance. <b>Compound Medications</b> covered only at a <a href="#">network</a> pharmacy.
	<a href="#">Specialty drugs</a>	40% coinsurance (with a \$100 maximum) <b>per 30 day supply</b> .	--none--	All fills must be filled through CVS Caremark Specialty (1-800-237-2767).

[\* 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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
	Physician/surgeon fees	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 copay plus deductible and 20% coinsurance	\$100 copay plus deductible and 20% coinsurance	Must meet emergency criteria. Copay waived if admitted within 24 hours.
	<a href="#">Emergency medical transportation</a>	Deductible plus 20% coinsurance	Deductible plus 20% coinsurance	Must meet emergency criteria.
	<a href="#">Urgent care</a>	\$50 copayment / visit	Deductible plus 50% coinsurance	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
	Physician/surgeon fees	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 copayment for specialty physician	Deductible plus 50% coinsurance	\$20 copayment for group therapy sessions.
	Inpatient services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required for inpatient services. For help call New Directions at 1-800-952-5906.
<b>If you are pregnant</b>	Office visits	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Medical necessity is required for stays longer than 48/96 hours.
	Childbirth/delivery professional services	Deductible then 20% coinsurance	Deductible plus 50% coinsurance	Medical necessity is required for stays longer than 48/96 hours.
	Childbirth/delivery facility services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Medical necessity is required for stays longer than 48/96 hours.

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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 need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization may be required.
	<a href="#">Rehabilitation services</a>	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization required.
	<a href="#">Habilitation services</a>	Not covered	Not covered	Unless under Autism rider of the policy.
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	
	<a href="#">Durable medical equipment</a>	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior Authorization required.
	<a href="#">Hospice services</a>	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior Authorization may be required. Inpatient Hospice care limited to 6 months.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$0 copayment for first annual visit, then \$40 copayment per visit	Deductible plus 50% coinsurance	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered under Medical Plan	Not covered under Medical Plan	

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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
- Hearing aids
- Routine foot care
- Cosmetic surgery
- Long-term care
- Weight loss programs
- Dental care (Adult)
- Private-duty nursing

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

- Bariatric surgery
- Routine eye care (Adult)
- Infertility treatment
- Chiropractic care
- 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)

**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: TASC at 1-844-285-9985. You may also contact your state insurance department. 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).

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax returns unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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>	\$800
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### 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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$3,270</b>

### 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>	\$800
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### 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)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$3,500
<b>The total Joe would pay is</b>	<b>\$4,580</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$800
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

[Emergency room care](#) (including medical supplies)  
[Diagnostic test](#) (x-ray)  
[Durable medical equipment](#) (crutches)  
[Rehabilitation services](#) (physical therapy)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$1,310</b>

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

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