

**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](http://www.bcbsks.com) or call 1-800-332-0307. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other **bolded** terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-326-2088 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	<b>Network:</b> \$800 individual / \$1,600 family. <b>Non Network:</b> \$800 per Individual / \$1,600 per Family. Doesn't apply to preventive care.	Generally, you must pay all of the costs from <b>providers</b> up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .
Are there services covered before you meet your <b>deductible</b> ?	Yes, preventive care with Network providers.	You will have to meet the <b>deductible</b> before the plan pays for any services. This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply.
Are there other <b>deductibles</b> for specific services?	No. There are no other specific <b>deductibles</b> .	You don't have to meet <b>deductibles</b> for specific services.
What is the <b>out-of-pocket limit</b> for this <b>plan</b> ?	Medical and Pharmacy combined <b>Out of Pocket:</b> <b>Network:</b> \$5,250 Ind. / \$10,500 Family. <b>Non Network:</b> \$5,250 Ind. / \$10,500 Family <b>Network</b> and <b>Non Network</b> accumulators apply separately.	The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <b>out-of-pocket limits</b> until the overall family <b>out-of-pocket limit</b> has been met.
What is not included in the <b>out-of-pocket limit</b> ?	<b>Premiums</b> , <b>balance-billing</b> charges, and health care this <b>plan</b> doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use a <b>Network provider</b> ?	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 <b>plan</b> uses a <b>provider Network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's Network</b> . You will pay the most if you use a <b>Non Network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>Network provider</b> might use a <b>Non Network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without a <b>referral</b> .

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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)	Non 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	
	<b>Specialist</b> visit	\$40 copayment / visit	Deductible plus 50% coinsurance	
	<b>Preventive care/screening/immunization</b>	\$0 copayment	Deductible plus 50% coinsurance	Breast Cancer Screenings (Mammograms, Ultrasounds, and MRI's) and Pap Smears - Not limited to once per year / <b>Network</b> 100% regardless of diagnosis. Immunizations with <b>Non Network</b> providers covered in full up to age 6 only. 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.
<b>If you have a test</b>	<b>Diagnostic test</b> (x-ray, blood work)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Covered lab services paid at 100% when using preferred labs (Quest, Stormont Vail, and The University of Kansas Health 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>  <b>Prescription drug coverage is administered by Caremark</b>  More information about <b>Prescription drug coverage</b> 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. Contraceptives: 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 <b>Network</b> Pharmacy.

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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)	Non 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.caremark.com">www.caremark.com</a></p>	<a href="#">Specialty drugs*</a>	30% coinsurance (with a \$100 maximum) <b>per 30 day supply.</b>	--none--	All fills must be filled through CVS Caremark Specialty (1-800-294-6324).
<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 or Residential Treatment Facilities*	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required for inpatient services or Residential Treatment Facilities. For help call Lucet 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.

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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)	Non Network Provider (You will pay the most)	
<b>If you are pregnant</b>	Childbirth/delivery facility services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Medical necessity is required for stays longer than 48/96 hours.
<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>	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
	<a href="#">Durable medical equipment</a>	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior Authorization may be required by the TPA.
	<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 \$60 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
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Private-duty nursing
- Dental care (Adult)
- Routine foot care

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

- Bariatric surgery
- 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)
- Hearing aids - \$5,000 maximum/3 years
- Routine eye care (Adult)
- Infertility treatment
- Chiropractic care

**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: 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](#). 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: 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](#) 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 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 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](#)

<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

(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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