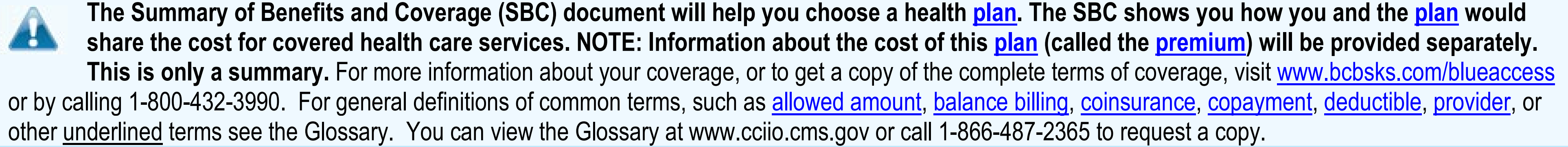
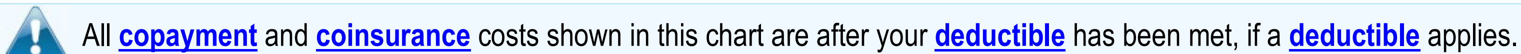


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsks.com/blueaccess or by calling 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,500 individual / $3,000 family; for out-of-network providers $6,350 individual / $12,700 family	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 is covered before you meet your deductible.	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/. See the SBC of the insured group health plan.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $8,350 individual / $16,700 family	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?	Copayments for certain services, 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022) (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)



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/office visit, deductible does not apply.	20% coinsurance	See the SBC of the insured group health plan.
	Specialist visit	$25 copay/visit, deductible does not apply.	20% coinsurance	See the SBC of the insured group health plan.
	Preventive care/screening/ immunization	No charge (covered in full by the group health plan).	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. See the SBC of the insured group health plan.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance First $300 covered at 100%.	20% coinsurance	See the SBC of the insured group health plan.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsks.com	Generic drugs (Tier 1)	Deductible does not apply. Retail: $15 Mail-Order/Retail: $37.50	Deductible does not apply. Retail: $15	Covers up to a 30-day supply (retail prescription); 31-90 day supply (retail prescription). See the SBC of the insured group health plan.
	Preferred brand drugs (Tier 2)	Deductible does not apply. Retail: $100 Mail-Order/Retail: $250	Deductible does not apply. Retail: $100	
	Non-preferred brand drugs (Tier 3)	Deductible does not apply. Retail: $125 Mail-Order/Retail: $312.50	Deductible does not apply. Retail: $125	
	Specialty drugs (Tier 4)	50% coinsurance	20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	20% coinsurance	See the SBC of the insured group health plan.
	Physician/surgeon fees	50% coinsurance	20% coinsurance	See the SBC of the insured group health plan.
If you need immediate medical attention	Emergency room care	50% coinsurance. $250 copay/ visit	20% coinsurance	See the SBC of the insured group health plan.
	Emergency medical transportation	50% coinsurance	20% coinsurance	
	Urgent care	$25 copay/visit. Deductible does not	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		apply.		
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	20% coinsurance	See the SBC of the insured group health plan.
	Physician/surgeon fees	50% coinsurance	20% coinsurance	See the SBC of the insured group health plan.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit Deductible does not apply.	20% coinsurance	See the SBC of the insured group health plan.
	Inpatient services	50% coinsurance	20% coinsurance	
If you are pregnant	Office visits	50% coinsurance	20% coinsurance	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC. See the SBC of the insured group health plan.
	Childbirth/delivery professional services	50% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	50% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	20% coinsurance	See the SBC of the insured group health plan.
	Rehabilitation services	50% coinsurance	20% coinsurance	See the SBC of the insured group health plan.
	Habilitation services	50% coinsurance	20% coinsurance	
	Skilled nursing care	50% coinsurance	20% coinsurance	See the SBC of the insured group health plan.
	Durable medical equipment	50% coinsurance	20% coinsurance	See the SBC of the insured group health plan.
	Hospice services	50% coinsurance	20% coinsurance	See the SBC of the insured group health plan.
If your child needs dental or eye care	Children's eye exam	$25 copay/office visit Deductible does not apply.	20% coinsurance	See the SBC of the insured group health plan.
	Children's glasses	Benefits applied by the insured group health plan.	Benefits applied by the insured group health plan.	See the SBC of the insured group health plan.
	Children's dental check-up	Benefits applied by the insured group health plan.	Benefits applied by the insured group health plan.	See the SBC of the insured group health plan.

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 Program
- Any expense not reimbursed by the insured group health plan

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Infertility treatment • Non-emergency Treatment when traveling outside the U.S.	• 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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or www.cciio.cms.gov. 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 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: Freedom Claims Management, Inc. at 1-866-792-9151.Additionally, a consumer assistance program can help you file your appeal. Contact the Kansas Insurance Dept at 1-800-432-2484 or visit www.ksinsurance.org.

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 return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 620-792-9151.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 620-792-9151.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 620-792-9151.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 620-792-9151.]

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 **plan's** overall **deductible** **$1,500**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$40
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,600**

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** **$25**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$260
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,790**

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

- The **plan's** overall **deductible** **$1,500**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$250
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,830**

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