

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 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 or call 1-800-432-3990 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$1,000 person / \$2,000 family. Doesn't apply to In-Network preventive care.	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.	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/ .
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Coinsurance is 20% to a max of \$2,500 person / \$5,000 family. Total out of pocket max is \$5,000 person / \$10,000 family. 20% non PPO penalty applies annually up to \$2,000 person / \$4,000 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?	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).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.		

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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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copay/visit	\$35 copay/visit	_____none_____
	Specialist visit	\$35 copay/visit	\$35 copay/visit	_____none_____
	Preventive care/screening/immunization	\$0. Preventive is without cost share.	Deductible then 20% coinsurance	Immunizations as identified by the Center of Medicare and Medicaid Services.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$0 up to \$300 person, deductible then 20% coinsurance	\$0 up to \$300 person, deductible then 20% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	\$0 up to \$300 person, deductible then 20% coinsurance	\$0 up to \$300 person, deductible then 20% coinsurance	_____none_____
	Generic drugs	\$15 copay	\$15 copay	_____none_____
If you need drugs to treat your illness or condition	Preferred brand drugs	\$50 copay	\$50 copay	_____none_____
	Non-preferred brand drugs	\$75 copay	\$75 copay	_____none_____
	Specialty drugs	Copay 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	\$250 copay then deductible and 20% coinsurance	\$250 copay then deductible and 20% coinsurance	_____none_____
	<u>Emergency medical transportation</u>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Urgent care</u>	Copay is applicable to the provider type	Copay is applicable to the provider type	Same as office visit.
	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
If you have a hospital stay	Outpatient services	\$35 copay/visit, other outpatient services subject to deductible then 20% coinsurance	\$35 copay/visit, other outpatient services subject to deductible then 20% coinsurance	_____none_____
	Inpatient services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	Office visits	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
If you are pregnant	Childbirth/delivery professional services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	Childbirth/delivery facility services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	<u>Home health care</u>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	<u>Habilitation services</u>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	<u>Skilled nursing care</u>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	<u>Durable medical equipment</u>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Hospice services</u>	Deductible then 20% coinsurance	Deductible then 20% coinsurance	_____none_____
	Children's eye exam	Copay is applicable to the provider type	Copay is applicable to the provider type	Same as specialist visit unless vision screening for children under 5 years which is covered at 100% as preventative.
If your child needs dental or eye care	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. • Private-duty nursing See www.bcbs.com/already-a-member/coverage-home-and-away.html
• 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, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit www.ksinsurance.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or 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 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, or the Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit www.ksinsurance.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 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

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

Chinese (中国): 中国

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwiilingo holne'

-To see examples of how this plan might cover costs for a sample medical situation, see the next section.

1-800-432-3990

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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 **\$1000**
- Specialist copay **\$35**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **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)

Total Example Cost **\$12840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1000
Copayments	\$130
Coinsurance	\$2480
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	
\$3670	

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$1000**
- Specialist copay **\$35**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **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)

Total Example Cost **\$7460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1000
Copayments	\$1465
Coinsurance	\$372
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	
\$2892	

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

- The plan's overall deductible **\$1000**
- Specialist copay **\$35**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **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)

Total Example Cost **\$2070**

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1000
Copayments	\$855
Coinsurance	\$215
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	
\$2070	

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

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Coverage for: Individual/Family | Plan Type: PPO



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Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$1,000 person / \$2,000 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 <u>deductible</u> ?	Yes, preventive care.	For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> 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 <u>out-of-pocket limit</u> for this <u>plan</u> ?	Coinsurance is 50% to a max of \$2,500 person / \$5,000 family. Total out of pocket max is \$5,000 person / \$10,000 family. 20% non PPO penalty applies annually up to \$2,000 person / \$4,000 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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	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 <u>network provider</u> ?	Yes. See www.bcbsks.com/providerdirectory 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>).
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.		

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	Specialist visit	\$35 copay/visit	\$35 copay/visit	_____none_____
	Preventive care/screening/immunization	\$0. Preventive is without cost share.	Deductible then 50% coinsurance	Immunizations as identified by the Center of Medicare and Medicaid Services.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 up to \$300 person, deductible then 50% coinsurance	\$0 up to \$300 person, deductible then 50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	\$0 up to \$300 person, deductible then 50% coinsurance	\$0 up to \$300 person, deductible then 50% coinsurance	_____none_____
	Generic drugs	\$15 copay	\$15 copay	_____none_____
If you need drugs to treat your illness or condition	Preferred brand drugs	\$50 copay	\$50 copay	_____none_____
	Non-preferred brand drugs	\$75 copay	\$75 copay	_____none_____
	Specialty drugs	Copay 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
	Physician/surgeon fees	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
If you need immediate medical attention	Emergency room care	\$250 copay then deductible and 50% coinsurance	\$250 copay then deductible and 50% coinsurance	_____none_____
	Emergency medical transportation	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____

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If you need immediate medical attention	<u>Urgent care</u>	Copay is applicable to the provider type	Copay is applicable to the provider type	Same as office visit.
	Facility fee (e.g., hospital room)	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
If you have a hospital stay	Physician/surgeon fees	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
	Outpatient services	\$35 copay/visit, other outpatient services subject to deductible then 50% coinsurance	\$35 copay/visit, other outpatient services subject to deductible then 50% coinsurance	_____none_____
If you need mental health, behavioral health, or substance abuse services	Inpatient services	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
	Office visits	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
If you are pregnant	Childbirth/delivery professional services	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
	Childbirth/delivery facility services	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
If you need help recovering or have other special health needs	<u>Home health care</u>	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
	<u>Rehabilitation services</u>	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
	<u>Habilitation services</u>	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
	<u>Skilled nursing care</u>	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
	<u>Durable medical equipment</u>	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____

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If you need help recovering or have other special health needs	<u>Hospice services</u>	Deductible then 50% coinsurance	Deductible then 50% coinsurance	_____none_____
	Children's eye exam	Copay is applicable to the provider type	Copay is applicable to the provider type	Same as specialist visit unless vision screening for children under 5 years which is covered at 100% as preventative.
If your child needs dental or eye care	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 .)	
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• Dental care (Adult)	• Hearing aids
• Weight loss programs	• 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. • Private-duty nursing See www.bcbs.com/already-a-member/coverage-home-and-away.html
• Routine eye care (Adult)	• Routine foot care • Spinal manipulations

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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](#), or the Kansas Insurance Department, 420 SW 9th Street, Topeka, Kansas 66612-1678, Phone: 800-432-2484, or visit [www.ksinsurance.org](#), or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](#).

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 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

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

Chinese (中国):

Navajo (Dine):
Dine'kehgo shika at'ohwol ninisingo, kwiiijigo holne'

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- To see examples of how this plan might cover costs for a sample medical situation, see the next section.

Questions: Call 1-800-432-3990 or visit us at www.bcbsks.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-432-3990 to request a copy.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ <u>The plan's overall deductible</u>	\$1000	■ <u>The plan's overall deductible</u>	\$1000	■ <u>The plan's overall deductible</u>	\$1000
■ <u>Specialist copay</u>	\$35	■ <u>Specialist copay</u>	\$35	■ <u>Specialist copay</u>	\$35
■ <u>Hospital (facility) coinsurance</u>	50%	■ <u>Hospital (facility) coinsurance</u>	50%	■ <u>Hospital (facility) coinsurance</u>	50%
■ <u>Other coinsurance</u>	50%	■ <u>Other coinsurance</u>	50%	■ <u>Other coinsurance</u>	50%
This EXAMPLE event includes services like:		This EXAMPLE event includes services like:		This EXAMPLE event includes services like:	
Specialist office visits (prenatal care)		Primary care physician office visits (including disease education)		Emergency room care (including medical supplies)	
Childbirth/Delivery Professional Services		Diagnostic tests (blood work)		Diagnostic test (x-ray)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (crutches)	
Diagnostic tests (ultrasounds and blood work)		Durable medical equipment (glucose meter)		Rehabilitation services (physical therapy)	
Total Example Cost	\$12840	Total Example Cost	\$7460	Total Example Cost	\$2141
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$1000	Deductibles	\$1000	Deductibles	\$749
Copayments	\$0	Copayments	\$1465	Copayments	\$855
Coinsurance	\$4000	Coinsurance	\$931	Coinsurance	\$537
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$55	Limits or exclusions	\$0
The total Peg would pay is	\$5060	The total Joe would pay is	\$3451	The total Mia would pay is	\$2141

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

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Blue Cross and Blue Shield of Kansas is an independent licensee of the Blue Cross Blue Shield Association.

CMMng 01/20

This information is being furnished in compliance with applicable federal regulations.

This Notice has important information. This notice has important information about your application or coverage through Blue Cross and Blue Shield of Kansas. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Please call 1-800-432-3990.

Discrimination is against the law.

Blue Cross and Blue Shield of Kansas (BCBSKS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSKS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Kansas:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Holly Graves.

If you believe that BCBSKS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Holly Graves, Director, Individual Sales and Customer Service, 1133 S.W. Topeka Blvd., Topeka, KS 66629-0001,
1-800-432-3990, TTY: 1-800-766-3777, Fax: 785-290-0711, CSC@bcbsks.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Holly Graves is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、ID カードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماس بگیرید..

