

## Summary of Benefits and Coverage: What this Plan Covers &amp; What You Pay For Covered Services

Coverage for: Individual/Family | Plan Type: EPO



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>\$0</b> at Indian Health Care Provider (IHCP) or with IHCP referral at Non-IHCP. <b>\$7,000</b> person / <b>\$14,000</b> family for Non-IHCP In-Network Provider. There is no coverage for Non-IHCP Out-of-Network Providers. 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?	No.	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> ?	<b>\$7,000</b> person / <b>\$14,000</b> family for In-Network. There is no coverage for Non-IHCP Out-of-Network services.	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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(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)



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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$0	Deductible then \$0	Not Covered	_____none_____
	<a href="#">Specialist</a> visit	\$0	Deductible then \$0	Not Covered	_____none_____
	<a href="#">Preventive care/screening</a> /immunization	\$0. Preventive is without cost share.	\$0. Preventive is without cost share.	Not Covered	Immunizations as identified by the Center of Medicare and Medicaid Services.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$0	Deductible then \$0	Not Covered	_____none_____
	Imaging (CT/PET scans, MRIs)	\$0	Deductible then \$0	Not Covered	_____none_____
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsks.com">www.bcbsks.com</a>	Generic drugs	\$0	Deductible then \$0	Not Covered	_____none_____
	Preferred brand drugs	\$0	Deductible then \$0	Not Covered	_____none_____
	Non-preferred brand drugs	\$0	Deductible then \$0	Not Covered	_____none_____
	<a href="#">Specialty drugs*</a>	\$0	Deductible then \$0	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)	\$0	Deductible then \$0	Not Covered	_____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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Physician/surgeon fees	\$0	Deductible then \$0	Not Covered	_____none_____
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$0	Deductible then \$0	Deductible then \$0	_____none_____
	<a href="#">Emergency medical transportation</a>	\$0	Deductible then \$0	Deductible then \$0	_____none_____
	<a href="#">Urgent care</a>	\$0	Deductible then \$0	Not Covered	For emergency services, out-of-network is subject to the in-network benefits.
If you have a hospital stay*	Facility fee (e.g., hospital room)	\$0	Deductible then \$0	Not Covered	_____none_____
	Physician/surgeon fees	\$0	Deductible then \$0	Not Covered	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0	Deductible then \$0	Not Covered	_____none_____
	Inpatient services*	\$0	Deductible then \$0	Not Covered	_____none_____
If you are pregnant	Office visits	\$0	Deductible then \$0	Not Covered	_____none_____
	Childbirth/delivery professional services	\$0	Deductible then \$0	Not Covered	_____none_____
	Childbirth/delivery facility services	\$0	Deductible then \$0	Not Covered	_____none_____

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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>	\$0	Deductible then \$0	Not Covered	—————none—————
	<a href="#">Rehabilitation services</a>	\$0	Deductible then \$0	Not Covered	Speech Therapy: Limited to 90 visits per Insured per benefit period.
	<a href="#">Habilitation services</a>	\$0	Deductible then \$0	Not Covered	—————none—————
	<a href="#">Skilled nursing care*</a>	Not Covered	Deductible then \$0	Not Covered	—————none—————
	<a href="#">Durable medical equipment</a>	\$0	Deductible then \$0	Not Covered	—————none—————
	<a href="#">Hospice services*</a>	\$0	Deductible then \$0	Not Covered	—————none—————
<b>If your child needs dental or eye care</b>	Children's eye exam	\$0	Deductible then \$0	Not Covered	Vision services are limited to Insureds through the benefit period in which they turn age 19. Screening for children under 5 years which is covered at 100% as Preventive.
	Children's glasses	\$0	Deductible then \$0	Not Covered	Eyeglasses are limited to Insureds through the benefit period in which they turn age 19.
	Children's dental check-up	\$0	\$0. Children's dental check-ups are without cost share.	Not Covered	Dental cleanings and periodic evaluations are covered at 100%. All other dental services are subject to deductible and/or coinsurance. Dental services are limited to Insureds through the benefit period in which they turn age 19.

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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](#).)

- Abortion (except in the case when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term 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)
- Routine eye care (Adult)
- 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
- Private-duty nursing
- 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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>. 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).

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**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? Not Applicable**

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	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, kwijigo 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>	\$7,000
■ <a href="#">Specialist deductible</a>	\$7,000
■ Hospital (facility) <a href="#">deductible</a>	\$7,000
■ Other <a href="#">deductible</a>	\$7,000

**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>	\$7,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$60

<b>The total Peg would pay is</b>	<b>\$7,060</b>
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**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>	\$7,000
■ <a href="#">Specialist deductible</a>	\$7,000
■ Hospital (facility) <a href="#">deductible</a>	\$7,000
■ Other <a href="#">deductible</a>	\$7,000

**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>	\$5,400
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$20

<b>The total Joe would pay is</b>	<b>\$5,420</b>
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**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,000
■ <a href="#">Specialist deductible</a>	\$7,000
■ Hospital (facility) <a href="#">deductible</a>	\$7,000
■ Other <a href="#">deductible</a>	\$7,000

**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>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$2,800</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.