

## 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> ?                                | \$0 person / \$0 family for In-Network. There is no coverage for Out-of-Network services. Doesn't apply to In-Network preventive care. | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | No.                                                                                                                                    | 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> ? | Not Applicable.                                                                                                                        | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Not Applicable.                                                                                                                        | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Not Applicable.                                                                                                                        | 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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(DOL - OMB control number: 1210-0147/Expiration Date: 5/31/2022)  
(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)<br>(You will pay the least) | Non-IHCP Provider<br>(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        | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                                                                                                                      |
|                                                               | <a href="#">Specialist</a> visit                        | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                                                                                                                      |
|                                                               | <a href="#">Preventive care/screening</a> /immunization | \$0. Preventive is without cost share.                         | \$0                                          | Out-of-Network services are not covered. Immunizations as identified by the Center of Medicare and Medicaid Services.                                                                                                                                                                                         |
| <b>If you have a test</b>                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)     | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                                                                                                                      |
|                                                               | Imaging (CT/PET scans, MRIs)                            | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                                                                                                                      |
| <b>If you need drugs to treat your illness or condition</b>   | Generic drugs                                           | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                                                                                                                      |
|                                                               | Preferred brand drugs                                   | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                                                                                                                      |
|                                                               | Non-preferred brand drugs                               | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                                                                                                                      |
|                                                               | <a href="#">Specialty drugs*</a>                        | \$0                                                            | \$0                                          | Out-of-Network services are 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. |
| <b>If you have outpatient surgery</b>                         | Facility fee (e.g., ambulatory surgery center)          | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                                                                                                                      |
|                                                               | Physician/surgeon fees                                  | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                                                                                                                      |
| <b>If you need immediate medical attention</b>                | <a href="#">Emergency room care</a>                     | \$0                                                            | \$0                                          | _____none_____                                                                                                                                                                                                                                                                                                |
|                                                               | <a href="#">Emergency medical transportation</a>        | \$0                                                            | \$0                                          | _____none_____                                                                                                                                                                                                                                                                                                |
|                                                               | <a href="#">Urgent care</a>                             | \$0                                                            | \$0                                          | Out-of-Network services are not covered. For emergency services, out-of-network is subject to the in-network benefits.                                                                                                                                                                                        |

[\* 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)<br>(You will pay the least) | Non-IHCP Provider<br>(You will pay the most) |                                                                                                                                                                                                                     |
| <b>If you have a hospital stay*</b>                                              | Facility fee (e.g., hospital room)        | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
|                                                                                  | Physician/surgeon fees                    | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
|                                                                                  | Inpatient services*                       | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
| <b>If you are pregnant</b>                                                       | Office visits                             | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
|                                                                                  | Childbirth/delivery professional services | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
|                                                                                  | Childbirth/delivery facility services     | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care*</a>         | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
|                                                                                  | <a href="#">Rehabilitation services</a>   | \$0                                                            | \$0                                          | Out-of-Network services are not covered. Speech Therapy: Limited to 90 visits per Insured per benefit period.                                                                                                       |
|                                                                                  | <a href="#">Habilitation services</a>     | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
|                                                                                  | <a href="#">Skilled nursing care*</a>     | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
|                                                                                  | <a href="#">Durable medical equipment</a> | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
|                                                                                  | <a href="#">Hospice services*</a>         | \$0                                                            | \$0                                          | Out-of-Network services are not covered.                                                                                                                                                                            |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | \$0                                                            | \$0                                          | Out-of-Network services are 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                                                            | \$0                                          | Out-of-Network services are not covered. Eyeglasses are limited to Insureds through the benefit period in which they turn age 19.                                                                                   |

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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)<br>(You will pay the least) | Non-IHCP Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                               |
| If your child needs dental or eye care | Children's dental check-up | \$0                                                            | \$0                                          | Out-of-Network services are 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> | \$0 |
| ■ <a href="#">Specialist deductible</a>                         | \$0 |
| ■ Hospital (facility) <a href="#">deductible</a>                | \$0 |
| ■ Other <a href="#">deductible</a>                              | \$0 |

**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> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |             |
|-----------------------------------|-------------|
| <a href="#">Deductibles</a>       | \$0         |
| <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>\$60</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> | \$0 |
| ■ <a href="#">Specialist deductible</a>                         | \$0 |
| ■ Hospital (facility) <a href="#">deductible</a>                | \$0 |
| ■ Other <a href="#">deductible</a>                              | \$0 |

**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> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |             |
|-----------------------------------|-------------|
| <a href="#">Deductibles</a>       | \$0         |
| <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>\$20</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> | \$0 |
| ■ <a href="#">Specialist deductible</a>                         | \$0 |
| ■ Hospital (facility) <a href="#">deductible</a>                | \$0 |
| ■ Other <a href="#">deductible</a>                              | \$0 |

**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> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <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>\$0</b> |

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