

Summary of Benefits and Coverage: What this Plan Covers & 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 . 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 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$5,900 person / \$11,800 family for In-Network. There is no coverage for Out-of-Network services. 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 <u>cost-sharing</u> and before you meet your <u>deductible</u> . 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 <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> ?	\$9,100 person / \$18,200 family for In-Network. There is no coverage for Out-of-Network services.	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 <a href="http://www.bcbsks.com/providerdirectory">www.bcbsks.com/providerdirectory</a> 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> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
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> .

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(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)



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$40 copay/visit	Not Covered	—————none—————
	<a href="#">Specialist</a> visit	\$80 copay/visit	Not Covered	—————none—————
	<a href="#">Preventive care/screening</a> /immunization	\$0. Preventive is without cost share.	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)	Deductible then 40% coinsurance	Not Covered	—————none—————
	Imaging (CT/PET scans, MRIs)	Deductible then 40% coinsurance	Not Covered	—————none—————
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsks.com">www.bcbsks.com</a>	Generic drugs	\$20 copay	Not Covered	Generic drugs are mandatory if available unless physician prescribes a brand drug.
	Preferred brand drugs	\$40 copay	Not Covered	—————none—————
	Non-preferred brand drugs	Deductible then \$80 copay	Not Covered	—————none—————
	<a href="#">Specialty drugs*</a>	Deductible then \$350 copay	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)	Deductible then 40% coinsurance	Not Covered	—————none—————
	Physician/surgeon fees	Deductible then 40% coinsurance	Not Covered	—————none—————
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Deductible then 40% coinsurance	Deductible then 40% coinsurance	—————none—————
	<a href="#">Emergency medical transportation</a>	Deductible then 40% coinsurance	Deductible then 40% coinsurance	—————none—————

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need immediate medical attention</b>	<a href="#">Urgent care</a>	\$60 copay/visit	Not Covered	For emergency services, out-of-network is subject to the in-network benefits.
<b>If you have a hospital stay*</b>	Facility fee (e.g., hospital room)	Deductible then 40% coinsurance	Not Covered	—————none—————
	Physician/surgeon fees	Deductible then 40% coinsurance	Not Covered	—————none—————
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40 copay/visit	Not Covered	—————none—————
	Inpatient services*	Deductible then 40% coinsurance	Not Covered	—————none—————
<b>If you are pregnant</b>	Office visits	Deductible then 40% coinsurance	Not Covered	—————none—————
	Childbirth/delivery professional services	Deductible then 40% coinsurance	Not Covered	—————none—————
	Childbirth/delivery facility services	Deductible then 40% coinsurance	Not Covered	—————none—————
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care*</a>	Deductible then 40% coinsurance	Not Covered	—————none—————
	<a href="#">Rehabilitation services</a>	Deductible then 40% coinsurance	Not Covered	Speech Therapy: \$40 copay, limited to 90 visits per Insured per benefit period. Occupational Physical Therapy \$40 copay.
	<a href="#">Habilitation services</a>	Deductible then 40% coinsurance	Not Covered	—————none—————
	<a href="#">Skilled nursing care*</a>	Deductible then 40% coinsurance	Not Covered	—————none—————
	<a href="#">Durable medical equipment</a>	Deductible then 40% coinsurance	Not Covered	—————none—————

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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 need help recovering or have other special health needs	<a href="#">Hospice services*</a>	Deductible then 40% coinsurance	Not Covered	_____none_____
If your child needs dental or eye care	Children's eye exam	\$80 copay/visit	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	Deductible then 40% coinsurance	Not Covered	Eyeglasses are limited to Insureds through the benefit period in which they turn age 19.
	Children's dental check-up	\$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)
- Cosmetic surgery
- Long-term care
- Acupuncture
- Dental care (Adult)
- 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)
- Bariatric surgery
- Hearing aids
- Routine eye care (Adult)

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

- Infertility treatment
- Spinal manipulations
- Private-duty nursing
- Weight loss programs
- Routine foot care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Blue Cross and Blue Shield of Kansas Customer Service at 1-800-432-3990. You may also contact your state insurance department, Kansas Insurance Department, 1300 SW Arrowhead Road, Topeka, Kansas 66604, Phone: 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).

### 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](#).

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## 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>	\$5,900
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

**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>	\$5,900
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,670</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>	\$5,900
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

**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>	\$900
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,020</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>	\$5,900
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

**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>	\$2,100
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,500</b>

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

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