

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 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 or call to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$1,500 person / \$3,000 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 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> ?	\$8,700 person / \$17,400 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 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>). 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> .

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.



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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit	Not Covered	_____none_____
	Specialist visit	\$60 copay/visit	Not Covered	_____none_____
	Preventive care/screening /immunization	\$0. Preventive is without cost share.	Not Covered	Immunizations as identified by the Center of Medicare and Medicaid Services.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 25% coinsurance	Not Covered	_____none_____
	Imaging (CT/PET scans, MRIs)	Deductible then 25% coinsurance	Not Covered	_____none_____
If you need drugs to treat your illness or condition	Generic drugs	\$15 copay	Not Covered	Generic drugs are mandatory if available unless physician prescribes a brand drug.
	Preferred brand drugs	\$30 copay	Not Covered	_____none_____
	Non-preferred brand drugs	\$60 copay	Not Covered	_____none_____
	More information about prescription drug coverage is available at www.bcbsks.com	Specialty drugs*	\$250 copay	Not Covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 25% coinsurance	Not Covered	_____none_____
	Physician/surgeon fees	Deductible then 25% coinsurance	Not Covered	_____none_____
If you need immediate medical attention	Emergency room care	Deductible then 25% coinsurance	Deductible then 25% coinsurance	_____none_____
	Emergency medical transportation	Deductible then 25% coinsurance	Deductible then 25% coinsurance	_____none_____
	Urgent care	\$45 copay/visit	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.]

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.

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 have a hospital stay*	Facility fee (e.g., hospital room)	Deductible then 25% coinsurance	Not Covered	_____none_____
	Physician/surgeon fees	Deductible then 25% coinsurance	Not Covered	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay/visit	Not Covered	_____none_____
	Inpatient services*	Deductible then 25% coinsurance	Not Covered	_____none_____
If you are pregnant	Office visits	Deductible then 25% coinsurance	Not Covered	_____none_____
	Childbirth/delivery professional services	Deductible then 25% coinsurance	Not Covered	_____none_____
	Childbirth/delivery facility services	Deductible then 25% coinsurance	Not Covered	_____none_____
If you need help recovering or have other special health needs	Home health care*	Deductible then 25% coinsurance	Not Covered	_____none_____
	Rehabilitation services	Deductible then 25% coinsurance	Not Covered	Speech Therapy: \$30 copay, limited to 90 visits per Insured per benefit period. Occupational Physical Therapy \$30 copay.
	Habilitation services	Deductible then 25% coinsurance	Not Covered	_____none_____
	Skilled nursing care*	Deductible then 25% coinsurance	Not Covered	_____none_____
	Durable medical equipment	Deductible then 25% coinsurance	Not Covered	_____none_____
	Hospice services*	Deductible then 25% coinsurance	Not Covered	_____none_____
If your child needs dental or eye care	Children's eye exam	\$60 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.

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.bcbsks.com.]

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.

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 your child needs dental or eye care	Children's glasses	Deductible then 25% 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.

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.bcbsks.com.]

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.

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

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, 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 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, 1300 SW Arrowhead Road, Topeka, Kansas 66604, Phone: 800-432-2484, or visit 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](#).

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.bcbsks.com.]

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.

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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.bcbsks.com.]

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)

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

This EXAMPLE event includes services like:

[Specialist](#) office visits (prenatal care)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (ultrasounds and blood work)
[Specialist](#) visit (anesthesia)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$2,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,370

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (including disease education)
[Diagnostic tests](#) (blood work)
[Prescription drugs](#)
[Durable medical equipment](#)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$300
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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

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.

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

BlueCareEPOStandardizedGold 01/24