

## 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>\$8,300</b> person / <b>\$16,600</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>\$9,300</b> person / <b>\$18,600</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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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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$0	\$40 copay/visit for 2 visits; once 2 visits are met, visits are subject to deductible then \$0	Not Covered	Telemedicine: Office visits provided via Telemedicine will be paid at 100% of the allowable charge. All other services provided via Telemedicine are subject to the same Cost Sharing provisions as a Non-Telemedicine service.
	<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. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<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_____
<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>	Tier 1 (Generic Preferred)	\$0	\$10 copay	Not Covered	Copay applies until Maximum Out-of-Pocket is met.
	Tier 2 (Generic Non-Preferred)		\$30 copay		
	Tier 3 (Brand Preferred)	\$0	Deductible then 50% coinsurance	Not Covered	After deductible is met, coinsurance applies until Maximum Out-of-Pocket is met.
	Tier 4 (Brand Non-Preferred)	\$0	Deductible then 50% coinsurance	Not Covered	After deductible is met, coinsurance applies until Maximum Out-of-Pocket is met.

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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 drugs to treat your illness or condition</b>  More information about <a href="http://www.bcbsks.com">prescription drug coverage</a> is available at <a href="http://www.bcbsks.com">www.bcbsks.com</a>	<a href="#">Tier 5* (Specialty Preferred)</a>  <a href="#">Tier 6* (Specialty-Non-preferred)</a>	\$0	Deductible then 50% coinsurance	Not Covered	After deductible is met, coinsurance applies until Maximum Out-of-Pocket is met. 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	Deductible then \$0	Not Covered	_____none_____
	Physician/surgeon fees	\$0	Deductible then \$0	Not Covered	_____none_____
<b>If you need immediate medical attention</b>	<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	\$40 copay/visit	Not Covered	Same as office visit. 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)	\$0	Deductible then \$0	Not Covered	_____none_____
	Physician/surgeon fees	\$0	Deductible then \$0	Not Covered	_____none_____

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		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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$0	\$0. Emergency room, ambulance or urgent care services; please see applicable sections for coverage information.	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_____
If you need help recovering or have other special health needs	<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_____

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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 your child needs dental or eye care	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)

### 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 Department of Insurance, 1300 SW Arrowhead Road, Topeka, Kansas 66604, Phone: 1-800-432-2484, 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 Department of Insurance, 1300 SW Arrowhead Road, Topeka, Kansas 66604, Phone: 1-800-432-2484, 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)		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)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$8,300	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$8,300	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$8,300
■ <a href="#">Specialist deductible</a>	\$8,300	■ <a href="#">Specialist deductible</a>	\$8,300	■ <a href="#">Specialist deductible</a>	\$8,300
■ Hospital (facility) <a href="#">deductible</a>	\$8,300	■ Hospital (facility) <a href="#">deductible</a>	\$8,300	■ Hospital (facility) <a href="#">deductible</a>	\$8,300
■ Other <a href="#">deductible</a>	\$8,300	■ Other <a href="#">deductible</a>	\$8,300	■ Other <a href="#">deductible</a>	\$8,300
This EXAMPLE event includes services like:		This EXAMPLE event includes services like:		This EXAMPLE event includes services like:	
<a href="#">Specialist</a> office visits (prenatal care)		<a href="#">Primary care physician</a> office visits (including disease education)		<a href="#">Emergency room care</a> (including medical supplies)	
Childbirth/Delivery Professional Services		<a href="#">Diagnostic tests</a> (blood work)		<a href="#">Diagnostic test</a> (x-ray)	
Childbirth/Delivery Facility Services		<a href="#">Prescription drugs</a>		<a href="#">Durable medical equipment</a> (crutches)	
<a href="#">Diagnostic tests</a> (ultrasounds and blood work)		<a href="#">Durable medical equipment</a>		<a href="#">Rehabilitation services</a> (physical therapy)	
<a href="#">Specialist</a> visit (anesthesia)					
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,810
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
<a href="#">Deductibles</a>	\$8,300	<a href="#">Deductibles</a>	\$1,500	<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$10	<a href="#">Copayments</a>	\$200	<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$300	Limits or exclusions	\$0
The total Peg would pay is	\$8,370	The total Joe would pay is	\$2,000	The total Mia would pay is	\$2,810

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.

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

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