

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 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 or call 1-800-432-3990 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall deductible ? | \$8,300 person / \$16,600 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 providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes, preventive care. | For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. There are no other specific deductibles . | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$9,300 person / \$18,600 family for In-Network. There is no coverage for Out-of-Network services. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums , balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See www.bcbsks.com/providerdirectory or call 1-800-432-3990 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | No. | You can see the specialist you choose without a referral . |

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 | \$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. |
| | Specialist visit | Deductible then \$0 | 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. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | Deductible then \$0 | Not Covered | —————none————— |
| | Imaging (CT/PET scans, MRIs) | Deductible then \$0 | Not Covered | —————none————— |
| If you need drugs to treat your illness or condition | Tier 1 (Generic Preferred) | \$10 copay | Not Covered | Copay applies until Maximum Out-of-Pocket is met. Generic drugs are mandatory if available unless physician prescribes a brand drug. |
| | Tier 2 (Generic Non-Preferred) | \$30 copay | Not Covered | After deductible is met, coinsurance applies until Maximum Out-of-Pocket is met. |
| | Tier 3 (Brand Preferred) | Deductible then 50% coinsurance | Not Covered | After deductible is met, coinsurance applies until Maximum Out-of-Pocket is met. |
| | Tier 4 (Brand Non-Preferred) | Deductible then 50% coinsurance | Not Covered | After deductible is met, coinsurance applies until Maximum Out-of-Pocket is met. |
| | Tier 5* (Specialty Preferred) | 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. |
| Tier 6* (Specialty Non-Preferred) | | | | |

[* 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 outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Deductible then \$0 | Not Covered | —————none————— |
| | Physician/surgeon fees | Deductible then \$0 | Not Covered | —————none————— |
| If you need immediate medical attention | Emergency room care | Deductible then \$0 | Deductible then \$0 | —————none————— |
| | Emergency medical transportation | Deductible then \$0 | Deductible then \$0 | —————none————— |
| | Urgent care | \$40 copay/visit | Not Covered | Same as office visit. 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) | Deductible then \$0 | Not Covered | —————none————— |
| | Physician/surgeon fees | Deductible then \$0 | Not Covered | —————none————— |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$0. Emergency room, ambulance or urgent care services: please see applicable sections for coverage information. | Not Covered | —————none————— |
| | Inpatient services* | Deductible then \$0 | Not Covered | —————none————— |
| If you are pregnant | Office visits | Deductible then \$0 | Not Covered | —————none————— |
| | Childbirth/delivery professional services | Deductible then \$0 | Not Covered | —————none————— |
| | Childbirth/delivery facility services | Deductible then \$0 | Not Covered | —————none————— |
| If you need help recovering or have other special health needs | Home health care* | Deductible then \$0 | Not Covered | —————none————— |
| | Rehabilitation services | Deductible then \$0 | Not Covered | Speech Therapy: Limited to 90 visits per Insured per benefit period. |
| | Habilitation services | Deductible then \$0 | Not Covered | —————none————— |
| | Skilled nursing care* | Deductible then \$0 | Not Covered | —————none————— |
| | Durable medical equipment | Deductible then \$0 | Not Covered | —————none————— |
| | Hospice services* | Deductible then \$0 | Not Covered | —————none————— |

[* 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 eye exam | 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 | 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. 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 Department of Insurance, 1300 SW Arrowhead Road, Topeka, Kansas 66604, Phone: 1-800-432-2484, 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 Department of Insurance, 1300 SW Arrowhead Road, Topeka, Kansas 66604, Phone: 1-800-432-2484, 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 | \$8,300 |
| ■ Specialist deductible | \$8,300 |
| ■ Hospital (facility) deductible | \$8,300 |
| ■ Other deductible | \$8,300 |

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 | \$8,300 |
| Copayments | \$10 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$8,370 |

Managing Joe's type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$8,300 |
| ■ Specialist deductible | \$8,300 |
| ■ Hospital (facility) deductible | \$8,300 |
| ■ Other deductible | \$8,300 |

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 | \$1,500 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$300 |
| The total Joe would pay is | \$2,000 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$8,300 |
| ■ Specialist deductible | \$8,300 |
| ■ Hospital (facility) deductible | \$8,300 |
| ■ Other deductible | \$8,300 |

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 | \$2,810 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$10 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,810 |

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.

BlueCareEPOBronzeChoice 01/25