

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> ? | \$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 <u>plan</u> covers. |
| 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> ? | \$1,800 person / \$3,600 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> . |

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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 |
|---|--|--|--|--|
| | | 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 | \$0 copay/visit | Not Covered | —————none————— |
| | Specialist visit | \$10 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) | Subject to 25% coinsurance | Not Covered | —————none————— |
| | Imaging (CT/PET scans, MRIs) | Subject to 25% coinsurance | Not Covered | —————none————— |
| If you need drugs to treat your illness or condition | Generic drugs | \$0 copay | Not Covered | Generic drugs are mandatory if available unless physician prescribes a brand drug. |
| | Preferred brand drugs | \$15 copay | Not Covered | —————none————— |
| | Non-preferred brand drugs | \$50 copay | Not Covered | —————none————— |
| | More information about prescription drug coverage is available at www.bcbsks.com | Specialty drugs* | \$150 copay | Not Covered |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Subject to 25% coinsurance | Not Covered | —————none————— |
| | Physician/surgeon fees | Subject to 25% coinsurance | Not Covered | —————none————— |
| If you need immediate medical attention | Emergency room care | Subject to 25% coinsurance | Subject to 25% coinsurance | —————none————— |
| | Emergency medical transportation | Subject to 25% coinsurance | Subject to 25% coinsurance | —————none————— |
| | Urgent care | \$5 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.]

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|--|---|--|--|--|
| | | 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) | Subject to 25% coinsurance | Not Covered | _____none_____ |
| | Physician/surgeon fees | Subject to 25% coinsurance | Not Covered | _____none_____ |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$0 copay/visit | Not Covered | _____none_____ |
| | Inpatient services* | Subject to 25% coinsurance | Not Covered | _____none_____ |
| If you are pregnant | Office visits | Subject to 25% coinsurance | Not Covered | _____none_____ |
| | Childbirth/delivery professional services | Subject to 25% coinsurance | Not Covered | _____none_____ |
| | Childbirth/delivery facility services | Subject to 25% coinsurance | Not Covered | _____none_____ |
| If you need help recovering or have other special health needs | Home health care* | Subject to 25% coinsurance | Not Covered | _____none_____ |
| | Rehabilitation services | Subject to 25% coinsurance | Not Covered | Speech Therapy: \$0 copay, limited to 90 visits per Insured per benefit period. Occupational Physical Therapy \$0 copay. |
| | Habilitation services | Subject to 25% coinsurance | Not Covered | _____none_____ |
| | Skilled nursing care* | Subject to 25% coinsurance | Not Covered | _____none_____ |
| | Durable medical equipment | Subject to 25% coinsurance | Not Covered | _____none_____ |
| | Hospice services* | Subject to 25% coinsurance | Not Covered | _____none_____ |
| If your child needs dental or eye care | Children's eye exam | \$10 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. |

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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 your child needs dental or eye care | Children's glasses | Subject to 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. |

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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
- 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](#).

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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 plan's overall deductible | \$0 |
| ■ Specialist copayment | \$10 |
| ■ 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 | \$0 |
| Copayments | \$0 |
| Coinsurance | \$1,800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,860 |

Managing Joe's type 2 Diabetes

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

| | |
|---|------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$10 |
| ■ 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 | \$0 |
| Copayments | \$200 |
| Coinsurance | \$500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$720 |

Mia's Simple Fracture

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

| | |
|---|------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$10 |
| ■ 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 | \$0 |
| Copayments | \$30 |
| Coinsurance | \$600 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$630 |

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

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