



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

<https://ambetter.sunflowerhealthplan.com/2023-brochures.html>, or call 1-844-518-9505 (TTY/TDD 1-844-546-9713). 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 <https://www.healthcare.gov/sbc-glossary> or call 1-844-518-9505 (TTY/TDD 1-844-546-9713) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | \$6,100 individual / \$12,200 family. | 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. <u>Preventive care</u> services, primary care, <u>specialist</u> , and <u>urgent care</u> office visits, children's eye exam and glasses, lab-work, generic and preferred brand drugs are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. 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 <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | 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> ? | For <u>network providers</u> : \$7,500 individual / \$15,000 family. Not applicable for <u>out-of-network providers</u> . | 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, penalties for failure to obtain preauthorization for services 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 https://ambetter.sunflowerhealthplan.com/finda-doc or call 1-844-518-9505 (TTY/TDD 1-844-546-9713) 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> . |



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 | \$45 Copay / visit; deductible does not apply | Not covered | Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full, deductible does not apply. |
| | Specialist visit | \$100 Copay / visit; deductible does not apply | Not covered | Covered No Limit. |
| | Preventive care/screening/immunization | No charge; deductible does not apply | Not covered | 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) | \$50 Copay / test; deductible does not apply for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service | Not covered | Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details. |
| | Imaging (CT/PET scans, MRIs) | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need drugs to treat your illness or condition | Generic drugs (Tier 1) | Preferred Generic Retail: \$5 Copay / prescription; deductible does not apply Generic Retail: \$25 Copay / prescription; deductible does not apply | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. |

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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| More information about prescription drug coverage is available at https://ambetter.sunflowerhealthplan.com/2023formulary . | Preferred brand drugs (Tier 2) | Retail: \$75 Copay / prescription; deductible does not apply | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. |
| | Non-preferred brand drugs (Tier 3) | Retail: 50% Coinsurance | Not covered | |
| | Specialty drugs (Tier 4) | Retail: 50% Coinsurance | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need immediate medical attention | Emergency room care | 50% Coinsurance | 50% Coinsurance | Covered No Limit. |
| | Emergency medical transportation | 50% Coinsurance | 50% Coinsurance | Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of network ground/water ambulance provider , you may be subject to balance billing . |
| | Urgent care | \$60 Copay / visit; deductible does not apply | Not covered | Covered No Limit. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$45 Copay / office visit; deductible does not apply; 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. (Primary care provider (PCP) and other practitioner visits do not require prior authorization). |
| | Inpatient services | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |

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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office visits | \$45 Copay / visit; deductible does not apply | Not covered | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services , such as routine pre-natal and post-natal screenings . Depending on the type of services, coinsurance , deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 50% Coinsurance | Not covered | Prior authorization may be required. Cost-sharing does not apply for preventive services . Depending on the type of services, copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery facility services | 50% Coinsurance | Not covered | |
| If you need help recovering or have other special health needs | Home health care | 50% Coinsurance | Not covered | Prior authorization may be required. Note: Includes educational visits - limited to 3 per year. |
| | Rehabilitation services | Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance | Not covered | Outpatient: Prior authorization may be required. No limit per therapy for occupational and physical therapy; speech therapy limited to 1 service per day, up to a maximum benefit of 90 daily services per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit. |
| | Habilitation services | Outpatient: 50% Coinsurance Inpatient: | Not covered | Outpatient: Prior authorization may be required. Covered No Limit. |

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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | 50% Coinsurance | | Inpatient: Prior authorization may be required. Covered No Limit. |
| | Durable medical equipment | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Hospice services | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. Respite Care is covered as part of hospice services only. |
| If your child needs dental or eye care | Children's eye exam | No charge; deductible does not apply | Not covered | Eye exams are covered as appropriate. Additional visits beyond the initial exam will be billed as specialist visits. |
| | Children's glasses | No charge; deductible does not apply | Not covered | Limited to 3 sets of lenses and frames per year. |
| | Children's dental check-up | Not covered | Not covered | -----None----- |

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 .) | | |
|---|---|--|
| <ul style="list-style-type: none"> • Abortion (Except in cases of rape, incest, or when the life of the mother is endangered.) • Acupuncture • Bariatric surgery • Cosmetic surgery | <ul style="list-style-type: none"> • Dental Care (Children) • Infertility treatment (Limited to diagnosis and treatment of cause of infertility.) • Hearing aids • Long-Term Care (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.) | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Skilled nursing care • Weight loss programs |

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

- Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year per person.)
- Routine eye care (Adult-one visit & one item per year. Dollar allowance applies to hardware.)
- Spinal manipulation
- Private-duty nursing
- 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: Ambetter from Sunflower Health [Plan](#) at 1-844-518-9505 (TTY/TDD 1-844-546-9713); Kansas Insurance Department, 1300 SW Arrowhead Rd Topeka, KS 66604, Phone No. 1-785-296-3071.; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Kansas Health Options at 1-800-432-2484 ; Office of Personnel Management Multi State [Plan](#) Program at <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/>. 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 on how 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: Kansas Insurance Department, 1300 SW Arrowhead Rd Topeka, KS 66604, Phone No. 1-785-296-3071. Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-432-2484.

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](#).

Does this plan meet 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 1-844-518-9505 (TTY/TDD 1-844-546-9713).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-518-9505 (TTY/TDD 1-844-546-9713).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-518-9505 (TTY/TDD 1-844-546-9713).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-518-9505 (TTY/TDD 1-844-546-9713).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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](#) \$6,100
- [Specialist copayment](#) \$100
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$6,100 |
| Copayments | \$600 |
| Coinsurance | \$800 |
| What isn't covered | |
| Limits or exclusions | 60.00 |
| The total Peg would pay is | \$7,560 |

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$6,100
- [Specialist copayment](#) \$100
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)

Total Example Cost \$5,600

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$800 |
| Copayments | \$1,800 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,620 |

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$6,100
- [Specialist copayment](#) \$100
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic tests](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,500 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |

Statement of Non-Discrimination

Ambetter from Sunflower Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Sunflower Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Sunflower Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Ambetter from Sunflower Health Plan at 1-844-518-9505 (TTY 1-844-546-9713).

If you believe that Ambetter from Sunflower Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from Sunflower Health Plan Appeals Unit, 8325 Lenexa Dr, Suite 410, Lenexa, KS 66214, 1-844-518-9505 (TTY 1-844-546-9713), Fax 1-844-680-5805. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Sunflower Health Plan is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.