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 or call **1-800-332-0307**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other **bolded** terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-326-2088 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network EE Only **$2,750**; EE + Family: Individual **$3,300** / Family **$5,500**. Non Network: EE Only **$2,750**; EE + Family: Individual **$3,300** / Family **$5,500**.	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 with Network providers.	You will have to meet the deductible before the plan pays for any services. This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	Medical and Pharmacy combined Out-of-Pocket: Network: **$4,500** Ind. / **$9,000** Family Non Network: **$4,500** Ind. / **$9,000** Family Network and Non Network accumulators apply separately	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. For a list of preferred providers, see www.bcbsks.com or call 1-800-332-0307	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 Non 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 Non Network provider for some services (such as lab work). Check with your provider before you get services.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)
(DOL - OMB control number: 1210-0147/Expiration Date:5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Important Questions	Answers	Why this Matters:
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

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)	Non 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	Deductible plus 10% coinsurance	Deductible then 50% coinsurance	
	Specialist visit	Deductible then 10% coinsurance	Deductible then 50% coinsurance	
	Preventive care/screening/immunization	$0 copayment	Deductible then 50% coinsurance	Breast Cancer Screenings (Mammograms, Ultrasounds, and MRI's) and Pap Smears - Not limited to once per year / Network 100% regardless of diagnosis. Immunizations with Non Network providers covered in full up to age 6 only. 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 10% coinsurance	Deductible then 50% coinsurance	After deductible, covered lab services paid at 100% when using preferred labs (Quest, Stormont Vail, and the University of Kansas Health System).
	Imaging (CT/PET scans, MRIs)	Deductible then 10% coinsurance	Deductible then 50% coinsurance	
If you need drugs to treat your illness or condition **Prescription drug coverage is administered by Caremark** More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Deductible plus 20% coinsurance on the plans allowed charge.	Deductible plus 20% coinsurance on the plans allowed charge.	First fill is a 30 day supply at retail and mail. A 90 day supply is allowed at retail and mail for subsequent refills. Deductible: $2,750 Individual / $5,500 Family Out-of-Pocket Maximum: $4,500 Individual/$9,000 Family **Contraceptives**: Covered with 0% member coinsurance. **Non-Preferred Contraceptives**: Covered subject to 60% member coinsurance. Compound Medications covered only at a Network Pharmacy.
	Preferred brand drugs	35% coinsurance (retail or mail order)	35% coinsurance on the plans allowed charge	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Non-preferred brand drugs	60% coinsurance (retail or mail order)	60% coinsurance on the plans allowed charge.	
	Specialty drugs*	Deductible plus 30% coinsurance per **30 day supply.**	--none--	All fills must be filled through CVS Caremark Specialty (1-800-294-6324).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 10% coinsurance	Deductible then 50% coinsurance	
	Physician/surgeon fees	Deductible then 10% coinsurance	Deductible then 50% coinsurance	
If you need immediate medical attention	Emergency room care	Deductible then 10% coinsurance	Deductible then 10% coinsurance	Must meet emergency criteria.
	Emergency medical transportation	Deductible then 10% coinsurance	Deductible then 10% coinsurance	Must meet emergency criteria.
	Urgent care	Deductible then 10% coinsurance	Deductible then 50% coinsurance	
If you have a hospital stay*	Facility fee (e.g., hospital room)	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Prior authorization is required.
	Physician/surgeon fees	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Prior authorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible then 10% coinsurance	Deductible then 50% coinsurance	
	Inpatient service or Residential Treatment Facilities*	Deductible then 10% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required for inpatient services and Residential Treatment Facilities. For help call Lucet at 1-800-952-5906.
If you are pregnant	Office visits	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Medical necessity is required for stays longer than 48/96 hours.
	Childbirth/delivery professional services	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Medical necessity is required for stays longer than 48/96 hours.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non Network Provider (You will pay the most)	
If you are pregnant	Childbirth/delivery facility services	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Medical necessity is required for stays longer than 48/96 hours.
If you need help recovering or have other special health needs	Home health care*	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Prior authorization is required.
	Rehabilitation services	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Prior authorization may be required.
	Habilitation services	Not covered	Not covered	Unless under Autism rider of the policy.
	Skilled nursing care*	Deductible then10% coinsurance	Deductible then 50% coinsurance	Prior authorization is required.
	Durable medical equipment	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Prior authorization may be required by the TPA.
	Hospice services*	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Prior authorization may be required. Inpatient Hospice care limited to 6 months.
If your child needs dental or eye care	Children's eye exam	$0 copayment for first annual visit, then deductible plus 10% coinsurance.	Deductible then 50% coinsurance	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered under Medical Plan	Not Covered under Medical Plan	

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.)		
• Acupuncture	• Cosmetic surgery	• Dental care (Adult)
• Long-term care	• Private-duty nursing	• Routine foot care
• Weight loss programs		

Other Covered Services (Limitation may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Chiropractic care	• Eye care (Adult)
• Hearing aids - $5,000 maximum / 3 years	• Infertility treatment	• Non-emergency care when traveling outside The U.S. See www.bcbs.com/already-a-member/coverage-home-and-away.html

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 www.dol.gov/ebsa/healthreform. 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, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 the Minimum Value Standards? **Yes**
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.

[* For more information about limitations and exceptions, see the **plan** or policy document at **www.bcbsks.com.**]
Questions: Call **1-800-332-0307** or visit us at **www.bcbsks.com**. If you aren't clear about any of the **bolded** terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call **1-800-326-2088** to request a copy.

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, kwiijigo 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 Network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,750
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$2,750
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,820**

Managing Joe's type 2 Diabetes
(a year of routine Network care of a well-controlled condition)

The plan's overall deductible	$2,750
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$5,400**

Mia's Simple Fracture
(Network emergency room visit and follow up care)

The plan's overall deductible	$2,750
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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:

Cost Sharing	
Deductibles	$2,750
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,760**

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.
HDHPng 01/17