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: **$1,000** individual / **$2,000** family. Non Network: **$1,000** per Individual / **$2,000** per Family. Doesn't apply to 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 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: **$5,250** Ind / **$10,500** Family. Non Network: **$5,250** Ind / **$10,500** 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 a 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 a Non 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.

(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)

All copayment costs shown in this chart are before your deductible has been met, and all coinsurance costs 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	$20 copayment / visit	Deductible plus 50% coinsurance	
	Specialist visit	$60 copayment / visit	Deductible plus 50% coinsurance	
	Preventive care/screening/immunization	$0 copayment	Deductible plus 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 plus 20% coinsurance	Deductible plus 50% coinsurance	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 plus 20% coinsurance	Deductible plus 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	20% coinsurance (retail or mail order)	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.
	Preferred brand drugs	35% coinsurance (retail or mail order)	35% coinsurance on the plans allowed charge	**Diabetic** and **Asthma** medications that are considered **Generic** or **Preferred** brand with the following copays: **Generic** 10% coinsurance with a $20 maximum per 30 day supply. **Preferred** brand: 20% coinsurance with a $40 maximum per 30 day supply. Contraceptives: Covered with 0% member coinsurance.
	Non-preferred brand drugs	60% coinsurance (retail or mail order)	60% coinsurance on the plans allowed charge	**Non Preferred Contraceptives**: Covered subject to 65% coinsurance. **Compound Medications** covered only at a Network Pharmacy.

[* 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)	Out-of-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	Specialty drugs*	30% coinsurance (with a $100 maximum) **per 30 day supply**.	--none--	All fills must be filled through CVS Caremark Specialty (1-800-237-2767).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
	Physician/surgeon fees	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay plus deductible and 20% coinsurance	$100 copay plus deductible and 20% coinsurance	Must meet emergency criteria. Copay waived if admitted within 24 hours.
	Emergency medical transportation	Deductible plus 20% coinsurance	Deductible plus 20% coinsurance	Must meet emergency criteria.
	Urgent care	$50 copayment / visit	Deductible plus 50% coinsurance	
If you have a hospital stay*	Facility fee (e.g., hospital room)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
	Physician/surgeon fees	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment for specialty physician	Deductible plus 50% coinsurance	$20 copayment for group therapy sessions.
	Inpatient services or Residential Treatment Facilities*	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required for inpatient services or Residential Treatment Facilities. For help call Lucet at 1-800-952-5906.
If you are pregnant	Office visits	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Medical necessity is required for stays longer than 48/96 hours.
	Childbirth/delivery professional services	Deductible then 20% coinsurance	Deductible plus 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)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Childbirth/delivery facility services	Deductible plus 20% coinsurance	Deductible plus 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 plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization may be required.
	Rehabilitation services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization required.
	Habilitation services	Not covered	Not covered	Unless under Autism rider of the policy.
	Skilled nursing care*	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required
	Durable medical equipment	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior Authorization may be required by the TPA.
	Hospice services*	Deductible plus 20% coinsurance	Deductible plus 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 $60 copayment per visit	Deductible plus 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	• 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	• Routine eye care (Adult)	• Chiropractic 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: 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 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 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 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.

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	$1,000
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,000
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,370**

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

The plan's overall deductible	$1,000
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,000
Copayments	$200
Coinsurance	$40
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$4,740**

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

The plan's overall deductible	$1,000
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,000
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,410**

The plan would be responsible for the other costs of these EXAMPLE covered services.