This is only a summary. Please read the State Employee Health Plan Summary Plan Description that contains the complete terms of this plan. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at by calling 1-800-332-0307.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 2,750/Per Individual $ 5,500/Per Family Doesn't apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. **Copayments** and **coinsurance** amounts do not count toward your **deductible**, which generally starts over January 1st. When a covered service or supply is subject to a **deductible**, only the Plan allowance for the service or supply counts toward the **deductible**. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Network: $5,000/ Ind $10,000 / Family Non-Network: $5,000/Ind $10,000 / Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.bcbsks.com or call 1-800-332-0307.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See this plan's Summary Plan Description for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
	Specialist visit	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
	Other practitioner office visit	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Services for spinal manipulative therapy are limited to 30 visits per benefit year
	Preventive care/screening/immunization	$0 copayment	Not Covered	Colonoscopies, Mammograms and Pap Smears – Not limited to once per year / in network 100% regardless of diagnosis.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Discount to member when using preferred labs (Quest or Stormont Vail).
	Imaging (CT/PET scans, MRIs)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider (plus you may be balance billed)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	Deductible plus 20% coinsurance (retail or mail order)	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 / Ind $5,500 / Family **Out-of-Pocket Maximum:** $5,000 / Ind $10,000 / Family **Contraceptives:** Covered with 0% member coinsurance. **Non-Preferred Contraceptives:** Covered subject to member deductible and coinsurance. Compound medications covered only at a Network Pharmacy.
	Preferred brand drugs	Deductible plus 40% coinsurance (retail or mail order)	Deductible plus 40% coinsurance on the plans allowed charge	
	Non-preferred brand drugs	Deductible plus 65% coinsurance (retail or mail order)	Deductible plus 65% coinsurance on the plans allowed charge	
	Specialty drugs	Deductible plus 40% coinsurance **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	Prior Authorization is required.
	Physician/surgeon fees	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior Authorization is required.
If you need immediate medical attention	Emergency room services	Deductible plus 20% coinsurance	Deductible plus 20% coinsurance	Must meet emergency criteria.
	Emergency medical transportation	Deductible plus 20% coinsurance	Deductible plus 20% coinsurance	Must meet emergency criteria.
	Urgent care	Deductible plus 20% coinsurance	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 fee	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider (plus you may be balance billed)	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior Authorization is required for inpatient services. For help call MHNet at 1-866-607-5970.
	Mental/Behavioral health inpatient services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
	Substance use disorder outpatient services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
	Substance use disorder inpatient services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
If you are pregnant	Prenatal and postnatal care	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
	Delivery and all inpatient services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization 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 the Autism Rider of the policy.
	Skilled nursing care	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization required.
	Durable medical equipment	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization required.
	Hospice service	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization may be required. Inpatient Hospice care limited to 6 months.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider (plus you may be balance billed)	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$0 copayment for first annual visit, then deductible plus 20% coinsurance	Not a covered benefit	
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your Benefit Description for other excluded services.)**

- Acupuncture
- Cosmetic Surgery (to improve appearance of normal body structure)
- Hearing Aids
- Private Duty Nursing

Other Covered Services **(This isn't a complete list. Check your Benefit Description for other covered services and your costs for these services.)**

- Nutritional Evaluation and Diabetes Management
- Bariatric Surgery (for qualified patients)
- Hearing Exam to determine hearing loss and newborn screening
- 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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact COBRAGuard at 1-866-952-6272. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Customer Service at 1-800-432-3990 or you can visit www.bcbsks.com/blueaccess

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for coveraed services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Chinese:	此“保险金与覆盖范围概要”有中文版本，请致电-	1-800-432-3990
Spanish:	Este Resumen de Beneficios y Cobertura està disponible en español, por favor llame al	1-800-432-3990

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,540
- **Patient pays** $3,000

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,800
Copays	$0
Coinsurance	$900
Limits or exclusions	$200
Total	**$3,900**

* Recommended care for this example included over the counter medications which are excluded.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,560
- **Patient pays** $2,840

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,800
Copays	$0
Coinsurance	$500
Limits or exclusions	$80
Total	**$3,380**

* Recommended care for this example included over the counter medications which are excluded.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from non-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.