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. Please read the State Employee Health Plan Summary Plan Description that contains the complete terms of this plan. For general definitions of common terms, such as **allowed amount, balance billing, coinsurance, copayment, deductible, provider**, or other bolded terms please call 1-800-332-0307.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,000 individual / $2,000 two persons / $3,000 three or more persons. Non Network: $1,200 individual / $2,400 two persons / $3,600 three or more persons. 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.	For example, this **plan** covers certain **preventive services** without cost-sharing and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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: $6,250 Ind / $12,500 Family Non Network: $6,250 Ind / $12,500 Family	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**).
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

Deductible does not apply to In Network services.

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	$40 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	Mammograms and Pap Smears - Not limited to once per year / in network 100% regardless of diagnosis. Immunizations with Non Network providers covered in full up to age 6 only.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Lab services paid at 100% when using preferred labs (Quest or Stormont Vail).
	Imaging (CT/PET scans, MRIs)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	
If you need drugs to treat your illness or condition 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	40% coinsurance (retail or mail order)	40% 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 Contraceptives: Covered subject to 65% coinsurance.
	Non preferred brand drugs	65% coinsurance (retail or mail order)	65% coinsurance on the plans allowed charge	Compound Medications covered only at a Network Pharmacy.
	Specialty drugs	40% 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	Prior Authorization is required.

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 have outpatient surgery	Physician/surgeon fees	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior Authorization is required.
If you need immediate medical attention	Emergency room care	$100 copayment plus deductible and 20% coinsurance	$100 copayment 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	$40 copayment for specialty physician	Deductible plus 50% coinsurance	$20 copayment for group therapy sessions
	Inpatient services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required for inpatient services. For help call New Directions at 1-800-952-5906.
If you are pregnant	Office visits	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization required for stays longer than 48/96 hours
	Childbirth/delivery professional services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization required for stays longer than 48/96 hours
	Childbirth/delivery facility 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 Autism rider of the policy.

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 help recovering or have other special health needs	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization required.
	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 Benefit Description for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery (to improve appearance of normal body structure)
- Hearing aids
- Private-duty nursing

Other Covered Services (Limitation may apply to these services. This isn't a complete list. Please see your Benefit Description.)

- 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
- Nutritional Evaluation and Diabetes Management

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: TASC at 1-844-285-9985. You may also contact your state insurance department. 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.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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.

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	$1000
Specialist copay	$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	**$12840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1000
Copayments	$60
Coinsurance	$2337
What isn't covered	
Limits or exclusions	$96
The total Peg would pay is	**$3493**

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

The plan's overall deductible	$1000
Primary copay	$40
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 (glucose meter)

Total Example Cost	**$7460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1000
Copayments	$440
Coinsurance	$1193
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2688**

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

The plan's overall deductible	$1000
ER copay	$100
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	**$2010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1000
Copayments	$100
Coinsurance	$182
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1282**

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

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.