State Employee Health Plan: Plan C

Coverage Period: Beginning on or after 01/01/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | **Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Benefit Description at **www.bcbsks.com/blueaccess** or by calling **1-800-332-0307**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** person / **$5,000** 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. Check Benefit Description to see when the **deductible** starts over (usually, but not always, January 1st). 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. **$2,500** person / **$5,000** family. When using a Non Network provider **$4,000** person/**$8,000** 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, copayments, pharmacy coinsurance, 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. 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. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your Benefit Description for additional information about **excluded services**.

Questions: Call **1-800-332-0307** 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 **1-800-332-0307** to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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**, **copayments** and **coinsurance** 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	Limitations & Exceptions (All services must be medically necessary and appropriate)
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible then 0% coinsurance.	Deductible then 20% coinsurance.	
	Specialist visit	Deductible then 0% coinsurance.	Deductible then 20% coinsurance.	
	Other practitioner office visit	Deductible then 0% coinsurance.	Deductible then 20% coinsurance.	Manipulation therapies limited to 30 visits per year.
	Preventive care/screening/immunization	$0. Preventive is without cost share.	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 then 0% coinsurance	Deductible then 20% coinsurance.	
	Imaging (CT/PET scans, MRIs)	Deductible then 0% coinsurance	Deductible then 20% 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	Limitations & Exceptions (All services must be medically necessary and appropriate)
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	100% until deductible is met followed by 0% co-insurance (retail and mail order) per 31 day supply.	100% until deductible is met followed by 0% co-insurance (retail and mail order) per 31 day supply.	First fill is a 31 day supply at retail and mail. A 93 day supply is allowed at retail and mail for all subsequent fills. **Deductible:** $2,500 Single/$5,000 Family **Out of Pocket:** $2,500 Single/$5,000 Family **Contraceptives:** Covered at 0% member coinsurance.
	Preferred brand drugs	Same as Generic	Same as Generic	Same as Generic

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider	Limitations & Exceptions (All services must be medically necessary and appropriate)
	Non-preferred brand drugs	100% until deductible is met followed by 0% co-insurance (retail and mail order) per 31 day supply.	100% until deductible is met followed by 0% co-insurance (retail and mail order) per 31 day supply.	First fill is a 31 day supply at retail and mail. A 93 day supply is allowed at retail and mail for all subsequent fills. **Deductible:** $2,500 Single/$5,000 Family **Out of Pocket:** $2,500 Single/$5,000 Family Contraceptives that are not listed on the formulary will be subject to deductible.
	Specialty drugs	Same as Generic	Not Covered	First fill allowed at retail. All subsequent 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 then 0% coinsurance	Deductible then 20% coinsurance	
	Physician/surgeon fees	Deductible then 0% coinsurance	Deductible then 20% coinsurance	
If you need immediate medical attention	Emergency room services	Deductible then 0% coinsurance	Deductible then 0% coinsurance	Must meet emergency criteria. Copay waived if admitted with 24 hours.
	Emergency medical transportation	Deductible then 0% coinsurance	Deductible then 0% coinsurance	Must meet emergency criteria.
	Urgent care	Deductible then 0% coinsurance	Deductible then 20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 0% coinsurance	Deductible then 20% 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	Limitations & Exceptions (All services must be medically necessary and appropriate)
	Physician/surgeon fee	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Prior Authorization is required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health/Substance use disorder outpatient services	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Prior Authorization is required for inpatient service. For help call New Directions: 1-800-952-5906.
	Mental/Behavioral health/Substance use disorder inpatient services	Deductible then 0% coinsurance	Deductible then 20% coinsurance	
If you are pregnant	Prenatal and postnatal care, Delivery and all inpatient services	Deductible then 0% coinsurance	Deductible then 20% 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 then 0% coinsurance	Deductible then 20% coinsurance	Prior Authorization may be required.
	Rehabilitation services	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Prior Authorization is required.
	Habilitation services	Limited	Limited	See Autism Rider
	Skilled nursing care	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Prior Authorization is required.
	Durable medical equipment	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Prior Authorization required. Limited to $5,000 per benefit year.
	Hospice service	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Prior Authorization may be required. Inpatient Hospice care limited to 6 months.
If you or your child needs dental or eye care	Eye exam	$0 for first annual visit, then deductible then 0% coinsurance	Not Covered	
	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
- Hearing Aids
- Bariatric Surgery
- Cosmetic Surgery

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

- Nutritional Evaluation and Diabetes Management
- Hearing Exam to determine hearing loss and newborn screening
- Private Duty Nursing
- Most coverage provided outside the United States

  See www.bcbsks.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 the plan at 1-800-432-3990. 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 1-800-332-0307 or you can visit www.bcbsks.com/blueaccess.

Language Access Services:

Spanish (Español): Este Resumen de Beneficios y Cobertura està disponible en español, por favor llame al	1-800-432-3990
Chinese: 此“保险金与覆盖范围概要”有中文版本，请致电-	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** $4,840
- **Patient pays** $2,700

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	$2,500
Copays	$0
Coinsurance	$0
*Limits or exclusions	$200
Total	**$2,700**

***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** $2,700
- **Patient pays** $2,700

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	$2,500
Copays	$0
Coinsurance	$0
*Limits or exclusions	$200
Total	**$2,700**

***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 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.

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