

State Employee Health Plan: Plan B

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

Coverage Period: 01/01/13 to 12/31/13

Coverage for: All Coverage Levels | Plan Type: PPO



This is only a summary. Please read the State Employee Health Plan Benefit 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 1-855-326-2088.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$150/Per Individual \$ 300/Per Family	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. \$3,000/ Individual \$6,000 / 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 <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers , see www.chckansas.com or call 1-855-326-2088.	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 4. See this plan's Benefit Description for additional information about excluded services .

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- **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 (plus you may be balance billed)	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	\$20 copayment – Adult \$10 copayment – children age 18 and under	Deductible plus 50% coinsurance	
	Specialist visit	\$40 copayment – Adult \$25 copayment – children age 18 and under	Deductible plus 50% coinsurance	
	Other practitioner office visit	Deductible plus 35% coinsurance for spinal manipulative therapy	Deductible plus 50% coinsurance	Services for spinal manipulative therapy are limited to 30 visits per calendar year
	Preventive care/screening/immunization	\$0 copayment	Not Covered	Immunizations are covered for CDC recommended immunizations.
If you have a test	Diagnostic test (x ray, blood work)	\$0 copayment at Preferred Laboratory Providers	Deductible plus 50% coinsurance	
	Imaging (CT/PET scans, MRIs)	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior authorization required

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<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.caremark.com.</p>	Generic drugs	20% coinsurance (retail or mail order)	20% coinsurance on the plan's allowed charge	First fill is a 30 day supply at retail and mail. A 60 day supply is allowed at retail and mail for subsequent refills.
	Preferred brand drugs	35% coinsurance (retail or mail order)	35% coinsurance on the plan's allowed charge	
				Diabetic and Asthma medications that are considered generic or preferred brand with the following :
				Generic: 10% coinsurance with a \$10 maximum.
				Preferred brand: 20% coinsurance with a \$20 maximum.
			Contraceptives: Covered with 0% member coinsurance.	
	Non preferred brand drugs	60% coinsurance (retail or mail order)	60% coinsurance on plan's allowed charge	
	Specialty drugs	25% coinsurance with a \$75 maximum	Not covered	Specialty: First fill allowed at retail. All subsequent fills must be filled through CVS Caremark Specialty (1-800-237-2767)
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior Authorization is required.
	Physician/surgeon fees	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior Authorization is required.
<p>If you need immediate medical attention</p>	Emergency room services	\$100 copayment plus deductible and 35% coinsurance	\$100 copayment plus deductible and 35% coinsurance	Must meet emergency criteria. Copay waived if admitted within 24 hours.

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	Emergency medical transportation	Deductible plus 35% coinsurance	Deductible plus 35% coinsurance	Must meet emergency criteria.
	Urgent care	\$25 copayment plus deductible and 35% coinsurance	Deductible plus 50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required
	Physician/surgeon fee	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copayment – Adult \$10 copayment – children age 18 and under	Deductible plus 50% coinsurance	Prior Authorization is required. For help call MHNNet at 1-866-607-5970.
	Mental/Behavioral health inpatient services	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	
	Substance use disorder outpatient services	\$40 copayment – Adult \$25 copayment – children age 18 and under	Deductible plus 50% coinsurance	
	Substance use disorder inpatient services	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	
If you are pregnant	Prenatal and postnatal care	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	
	Delivery and all inpatient services	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior authorization required for stays longer than 48/96 hours

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If you need help recovering or have other special health needs	Home health care	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior authorization may be required.
	Rehabilitation services	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior authorization required.
	Habilitation services	Limited	Limited	See Autism Rider
	Skilled nursing care	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior authorization required.
	Durable medical equipment	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior authorization required. Limited to \$5,000 per benefit year.
	Hospice service	Deductible plus 35% coinsurance	Deductible plus 50% 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 \$40 copayment – Adult \$25 copayment – children age 18 and under	Not a covered benefit	
	Glasses	Not covered	Not covered	Separate policy available to purchase
	Dental check up	Not covered	Not covered	Separate policy available to purchase

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Acupuncture
- Cosmetic surgery (to improve appearance of normal body structure)

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

- Nutritional Evaluation & Diabetes
- Hearing exams to determine hearing loss and

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Management

newborn screening

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 1-855-326-2088. 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 Appeal Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For information about your **appeal** rights please see Part 3, “Appeal and External Review” in the Benefit Description. If you need assistance, you can contact: customer service at 1-855-326-2088.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-326-2088.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-326-2088.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-326-2088.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-326-2088

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 \$5,100**
- **Patient pays \$2,440**

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	\$150
Copays	\$0
Coinsurance	\$2,250
Limits or exclusions*	\$40
Total	\$2,440

*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 \$4,300**
- **Patient pays \$ 1,100**

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	\$150
Copays	\$400
Coinsurance	\$500
Limits or exclusions*	\$50
Total	\$1,100

*Recommended care for this example included
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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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