

## State Employee Health Plan: Plan C Qualified High Deductible Health Plan with Health Savings Account

Coverage Period: 01/01/2013 –12/31/2013

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

Coverage for: Employee + Family

Plan Type: PS1



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.myuhc.com](http://www.myuhc.com) or by calling 1-866-799-1324.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: <b>\$2,500</b> Individual* / <b>\$5,000</b> Family Non-Network: <b>\$2,500</b> Individual / <b>\$5,000</b> Family Doesn't apply to services listed below as "No Charge." Per Calendar Year. *Doesn't apply if policy covers 2+ people.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the Common Medical Events chart for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the Common Medical Events chart for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: <b>\$2,500</b> Individual / <b>\$5,000</b> Family Non-Network: <b>\$4,000</b> Individual / <b>\$8,000</b> 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?	Premium, balance-billed charges from non-network provider, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.	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 Common Medical Events chart 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, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-799-1324.	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.

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Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services.
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- Co-payments (copays) are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Co-insurance (co-ins) 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		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% co-ins*	20% co-ins*	None. *Deductible applies
	Specialist visit	0% co-ins*	20% co-ins*	None. *Deductible applies
	Other practitioner office visit	0% co-ins* for Manipulative (Chiropractic) Services	20% co-ins* for Manipulative (Chiropractic) Services	Limited to 26 visits of Manipulative (Chiropractic) services per policy period. *Deductible applies
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. No coverage non-network.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-ins*	20% co-ins*	None. *Deductible applies
	Imaging (CT / PET scans, MRIs)	0% co-ins*	20% co-ins*	None. *Deductible applies
If you need drugs to treat your illness or condition  More information about prescription drug coverage is available at <a href="http://www.caremark.com">www.caremark.com</a> or by calling 1-800-294-6324.	Tier 1: Lowest Amount – Generic Drugs	Retail / Mail-Order: Deductible plus 0% co-ins	Retail / Mail-Order: Deductible plus 0% co-ins on plan's allowed charge	First fill is a 30 day supply at retail or mail. A 60 day supply is allowed at retail or mail for all subsequent fills. Diabetic & Asthma medications that are considered generic or Preferred brand with the following copays: Generic: 10% co-ins with a \$10 maximum. Preferred Brand: 20% co-ins with a \$20 maximum. Contraceptives: covered with 0% member co-ins. *Deductible applies
	Tier 2: Mid Range Amount – Preferred Brand Drugs	Retail / Mail-Order: 0% co-ins*	Retail / Mail-Order: Deductible plus 0% co-ins on plan's allowed charge	

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		Network Provider	Non-Network Provider	
	Tier 3: High Cost Amount – Non-Preferred Brand Drugs	Retail / Mail-Order: 0% co-ins*	Retail / Mail-Order: 0% co-ins* on plan's allowed charge	First fill is a 30 day supply at retail or mail. A 60 day supply is allowed at retail or mail for all subsequent fills. Non-Preferred Diabetic & Asthma prescriptions: Covered subject to 60% member co-ins. Non-Preferred Contraceptives: Covered subject to 60% co-ins. *Deductible applies
	Tier 4: Additional High Cost Amount - Specialty Drugs	Retail / Mail-Order: 0% co-ins*	Not Applicable	First fill allowed at retail. All subsequent fills must be filled through CVS Caremark Specialty (1-800-237-2767). *Deductible applies
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% co-ins*	20% co-ins*	Prior Authorization required for non-network. *Deductible applies
	Physician / surgeon fees	0% co-ins*	20% co-ins*	None. *Deductible applies
<b>If you need immediate medical attention</b>	Emergency room services	0% co-ins*	20% co-ins*	Prior Authorization required non-network if results in an Inpatient Stay. *Deductible applies
	Emergency medical transportation	0% co-ins*	0% co-ins*	Prior Authorization is required for certain services. *Deductible applies
	Urgent care	0% co-ins*	20% co-ins*	None. *Deductible applies
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% co-ins*	20% co-ins*	Prior Authorization is required non-network for certain services. *Deductible applies
	Physician / surgeon fees	0% co-ins*	20% co-ins*	None. *Deductible applies
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental / Behavioral health outpatient services	0% co-ins*	20% co-ins*	Prior Authorization is required non-network for certain services. *Deductible applies
	Mental / Behavioral health inpatient services	0% co-ins*	20% co-ins*	Prior Authorization is required non-network for certain services. *Deductible applies
	Substance use disorder outpatient services	0% co-ins*	20% co-ins*	Prior Authorization is required non-network for certain services. *Deductible applies
	Substance use disorder inpatient	0% co-ins*	20% co-ins	Prior Authorization is required non-network for

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
	services			certain services. *Deductible applies
If you become pregnant	Prenatal and postnatal care	0% co-ins*	20% co-ins*	Routine pre-natal care is covered at No Charge. *Deductible applies
	Delivery and all inpatient services	0% co-ins*	20% co-ins*	Prior Authorization is required for certain services. *Deductible applies
If you have a recovery or other special health needs	Home health care	0% co-ins*	20% co-ins*	Prior Authorization is required non-network for certain services. *Deductible applies
	Rehabilitation services	0% co-ins*	20% co-ins*	Depending upon the type of therapy, there is a limit of 30 visits per policy period. *Deductible applies
	Habilitation services	0% co-ins^*	20% co-ins^*	^Limited autism services for children. *Deductible applies
	Skilled nursing care	0% co-ins*	20% co-ins	Prior Authorization is required non-network for certain services. *Deductible applies
	Durable medical equipment	0% co-ins*	20% co-ins*	Limited to \$5,000 per year. DME Repair - Any charges exceeding \$400 require pre-approval by health plan. Limited to \$2,500 per year. *Deductible applies
	Hospice service	0% co-ins*	20% co-insa8	Inpatient Hospice Care is limited to 6 months per lifetime. Outpatient Hospice Care is unlimited. Prior Authorization is required non-network for certain services. *Deductible applies
If your child needs dental or eye care	Eye exam	No Charge, initial visit only	Not Covered	Any subsequent visits within the calendar year are covered at deductible plus 0% co-ins. No coverage non-network.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

### Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

• Acupuncture	• Dental Care (Adult/Child)	• Long-term care
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<ul style="list-style-type: none"> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Glasses</li> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight Loss Programs</li> </ul>
<b>Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)</b>		
<ul style="list-style-type: none"> <li>Habilitation Services – may be covered with limitations</li> <li>Infertility Treatment – may be covered with limitations</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult) - may be covered with limitations</li> </ul>

### 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit <http://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 the Member Service number listed on the back of your ID card or visit [www.myuhc.com](http://www.myuhc.com).

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://www.cciio.cms.gov/prgrams/consumer/capgrants/index.html>.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.

若需要中文协助，请拨打您会员卡上的电话号码

Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniye nanitinigii number bikaa'igii bich'i' hodiilnih

Para sa tulong sa Tagalog, tawagan ang numero sa iyong

-----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
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$2,500
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions (example, over the counter meds, non-covered items)	\$200
<b>Total</b>	<b>\$2,700</b>

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

- Amount owed to providers: \$5,400
- Plan Pays \$ 2,820
- Patient Pays \$ 2,580

**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
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$2,500
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions (example, over the counter meds, non-covered items)	\$80
<b>Total</b>	<b>\$2,580</b>

## Questions and answers about Coverage Examples:

<p><b>What are some of the assumptions behind the Coverage Examples?</b></p> <ul style="list-style-type: none"> <li>• Costs don't include <b>premiums</b>.</li> <li>• Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.</li> <li>• The patient's condition was not an excluded or preexisting condition.</li> <li>• All services and treatments started and ended in the same coverage period.</li> <li>• There are no other medical expenses for any member covered under this plan.</li> <li>• Out-of-pocket expenses are based only on treating the condition in the example.</li> <li>• The patient received all care from in-network <b>providers</b>. If the patient had received care from out-of-network <b>providers</b>, costs would have been higher.</li> <li>• If other than individual coverage, the Patient Pays amount may be more.</li> </ul>	<p><b>What does a Coverage Example show?</b></p> <p>For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance 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.</p>	<p><b>Can I use Coverage Examples to compare plans?</b></p> <p>✓ <b>Yes</b>. 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</p>
	<p><b>Does the Coverage Example predict my own care needs?</b></p> <p>✗ <b>No</b>. 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.</p>	<p><b>Are there other costs I should consider when comparing plans?</b></p> <p>✓ <b>Yes</b>. An important cost is the <b>premium</b> you pay. Generally, the lower your <b>premium</b>, the more you'll pay in out-of-pocket costs, such as <b>co-payments</b>, <b>deductibles</b>, and <b>co-insurance</b>. 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.</p>
	<p><b>Does the Coverage Example predict my future expenses?</b></p> <p>✗ <b>No</b>. Coverage Examples are <b>not</b> 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.</p>	

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