# State and School Employees' Health Insurance Plan: Select

**Period: 01/01/2017 – 12/31/2017**

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

**Coverage: 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 policy or plan document at http://knowyourbenefits.dfa.ms.gov or by calling 1-866-586-2781.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,000 Individual In-Network**<br>**$2,000 Family In-Network**<br>Doesn't apply to preventive care or in-network PCP office visit. Prescription drug charges don't count toward the deductible. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The deductible starts over 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?** | **Yes. $75** for prescription drug expenses. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. There are no other specific deductibles. |
| **Is there an out–of–pocket limit on my expenses?** | Yes.<br>**$6,500 Individual In-Network**<br>**$13,000 Family In-Network** | 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 provided by network providers. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges, health care this Plan doesn't cover, and penalties for failure to obtain preauthorization 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 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 participating providers, http://knowyourbenefits.dfa.ms.gov or call 1-800-294-6307. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-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 can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | See your policy or plan document for 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 an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-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 participating **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care physician evaluation and management charge | $25, not subject to deductible | 40% coinsurance, subject to deductible | ----------none---------- |
| | PCP other services | 20% coinsurance, not subject to deductible | 40% coinsurance, subject to deductible | ----------none---------- |
| | Specialist office visit | 20% coinsurance | 40% coinsurance | Chiropractic services limited to a maximum of 30 visits per participant per calendar year. |
| | Preventive care/screening/immunization | No Charge | Not Covered | Based on covered Wellness/Preventive services. |
| **If you have a test** | Diagnostic test (X-ray, blood work) | 20% coinsurance | 40% coinsurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | ----------none---------- |
| **If you need drugs to treat your illness or condition** | Generic drugs | $12 copayment | $12 copayment | ----------none---------- |
| | Preferred brand drugs | $45 copayment | $45 copayment | ----------none---------- |
| | Nonpreferred brand drugs | $70 copayment | $70 copayment | ----------none---------- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| More information about **prescription drug coverage** is available at www.MyPrime.com | Specialty drugs | $70 copayment | Not Covered | ----------none---------- |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | ----------none---------- |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | ----------none---------- |
| **If you need immediate medical attention** | Emergency room services | 20% coinsurance | 40% coinsurance | $50 copayment for 1st visit; $200 copayment for each additional visit |
| | Emergency medical transportation | 20% coinsurance | 40% coinsurance | ----------none---------- |
| | Urgent care | 20% coinsurance | 40% coinsurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Certification required. $500 penalty for no notification; $250 penalty for late notification. |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance | ----------none---------- |
| **If you have mental health, behavioral health or substance abuse needs** | Mental/Behavioral health outpatient services | 20% coinsurance | 40% coinsurance | ----------none---------- |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 40% coinsurance | Certification required. $500 penalty for no notification; $250 penalty for late notification. |
| | Substance use disorder outpatient services | 20% coinsurance | 40% coinsurance | ----------none---------- |
| | Substance use disorder inpatient services | 20% coinsurance | 40% coinsurance | Certification required. $500 penalty for no notification; $250 penalty for late notification. |
| **If you are pregnant** | Prenatal care and physician delivery services | 20% coinsurance* | 40% coinsurance | * Certain services covered at 100% for participants who complete the maternity management program. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | All inpatient hospital services | 20% coinsurance | 40% coinsurance | ----------none---------- |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Requires certification |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Inpatient requires certification |
| | Habilitation services | 20% coinsurance | 40% coinsurance | Maintenance or exercise therapy is not covered. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Requires certification |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Based on allowable charge for basic equipment. |
| | Hospice service | 20% coinsurance | 40% coinsurance | Requires certification |
| **If your child needs dental or eye care** | Routine Eye exam | Not Covered | Not Covered | |
| | Glasses | Not Covered | Not Covered | |
| | Dental checkup | Not Covered | Not Covered | |

## 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
- Cosmetic surgery
- Hearing Aids
- Infertility treatment
- Routine dental care
- Routine eye care
- Routine foot care
- Weight loss programs (except as provided under wellness / preventive benefits or as specified in the Plan Document)

| **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.)** | |
|---|---|
| • Bariatric surgery | • Private duty and home health nursing |
| • Chiropractic Care | • Nonemergency care when traveling outside the U.S. |

## 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 Blue Cross & Blue Shield of Mississippi at 1-800-709-7881. 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 x 61565 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: Blue Cross & Blue Shield of Mississippi at 1-800-709-7881.

## 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?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

*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** $4,136
- **Patient pays** $3,404

**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 | $1,000 |
| Copays | $24 |
| Coinsurance | $1,480 |
| Limits or exclusions | $900 |
| **Total** | **$3,404** |

## Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,040
- **Patient pays** $1,360

**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 | $1,000 |
| Copays | $140 |
| Coinsurance | $220 |
| Limits or exclusions | $0 |
| **Total** | **$1,360** |

# 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 out-of-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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