State and School Employees' Health Insurance Plan: Select

Coverage Period: 01/01/2016 – 12/31/2016

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 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** **$2,000 Family In-Network** 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. Check your policy or plan document 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?	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. **$6,350 Individual – In-Network** **$12,700 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. 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.
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	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		
	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	
	Preferred brand drugs	$45 copayment	$45 copayment	
	Non-preferred brand drugs	$70 copayment	$70 copayment	

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	Based on allowable charge for basic equipment.
	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 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 policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Hearing Aids
- Infertility treatment
- Routine dental care (Adult)
- Routine eye care (Adult)
- 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
- Chiropractic care
- Organ Transplant
- Non-emergency care when traveling outside the U.S.
- Private duty nursing

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 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:** $9,540
- **Plan pays** $6,136
- **Patient pays** $3,404

Sample care costs:

Hospital charges (mother)	$4,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$9,540**

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**

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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 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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