**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

**Coverage Period: 01/01/2023 – 12/31/2023**

Mississippi State and School Employees' Health Insurance Plan: **Base**

**Coverage for:** Individual + Family | **Plan Type:** HDHP

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit http://www.dfa.ms.gov/insurance or call 1-800-709-7881. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can also view the Glossary at www.cciio.cms.gov.**

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network and Out-of-network: **$1,800**/individual; **$3,000**/family. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. In-network preventive care is covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **Are there other deductibles for specific services?** | Yes. Preventive prescription drugs: **$75**/individual. There are no other specific deductibles. | 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. |
| **What is the out-of-pocket limit for this plan?** | Network providers: **$6,500**/individual; **$13,000**/family.<br>Out-of-network providers: no out-of-pocket limit. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing, charges this health care plan doesn't cover and penalties for failure to obtain prior approval. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. Go here for a list of network providers or call 1-800-294-6307. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions and Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness<br>Specialist visit | 20% coinsurance | 40% coinsurance | Online provider visit: $10 (Subject to deductible) |
| | Preventive care/screening/ immunization | No charge. Deductible does not apply. | Not covered. | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (X-ray, blood work).<br>Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | |
| **If you need drugs to treat your illness or condition, or information about prescription drug coverage. Additional information is available at www.caremark.com** | Preferred Generic drugs | Retail: $12 copay<br>Mail order: $24 copay | You pay 100% then request reimbursement of the in-network amount, less the applicable deductible or copay. | $75 individual preventive prescription drug deductible (for certain preventive medications) if the Base Coverage deductible has not been met.<br>Mail Order (2X Copay) quantity 60-90 day supply.<br>No charge for FDA-approved generic contraceptives or brand name contraceptives if a generic is medically inappropriate or unavailable.<br>If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug plus the brand copayment.<br>Certain prescriptions require prior approval. |
| | Non-Preferred Generic drugs | Retail: $30 copay<br>Mail order: $60 copay | | |
| | Preferred brand drugs | Retail: $45 copay<br>Mail order: $90 copay | | |
| | Non-preferred brand drugs | Retail: $100 copay<br>Mail order: $200 copay | | |
| | Specialty drugs | Retail: $100 copay | Not covered. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center)<br>Provider/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance. | $50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance. | Copayment waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 40% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions and Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Urgent care | 20% coinsurance | 40% coinsurance | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room)<br>Provider/surgeon fees | 20% coinsurance | 40% coinsurance | Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250. |
| **If you need mental health, behavioral health or substance abuse services** | Outpatient services | 20% coinsurance | 40% coinsurance | |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250. |
| **If you are pregnant** | Office visits | 20% coinsurance | 40% coinsurance | Cost sharing does not apply for preventive services. Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive screenings) is not covered for dependent children. |
| | Childbirth/delivery professional services<br>Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Certification required. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Certification required. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | Maintenance or exercise therapy is excluded. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Certification required. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Coverage is limited to allowable charge for basic equipment. Prior approval recommended. |
| | Hospice services | 20% coinsurance | 40% coinsurance | Certification Required. Benefits available for up to six months. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered. | Not covered. | You must pay 100% of this service, even in network. |
| | Children's glasses | Not covered. | Not covered. | You must pay 100% of this service, even in network. |
| | Children's dental checkup | Not covered. | Not covered. | You must pay 100% of this service, even in network. |

## Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Acupuncture<br>• Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease)<br>• Dental care (Adult) | • Dental care (Children)<br>• Hearing aids<br>• Infertility treatment<br>• Routine eye care (Adult) | • Routine eye care (Children)<br>• Routine foot care<br>• Weight loss programs (except as required by ACA) |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Bariatric surgery (prior approval required)<br>• Chiropractic services (limited to 30 visits/individual/year) | • Non-emergency care when traveling outside the U.S. | • Private-duty nursing (prior approval required) |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.healthcare.gov/ or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, call the claims administrator at 1-800-709-7881. Additionally, a consumer assistance program can help you file your appeal. Contact Health Help Mississippi at 1-877- 314-3843 or healthhelpms@mhap.org.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

## Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $1,800 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| | |
|---|---|
| **Total Example Cost** | **$12,800** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,800 |
| Copayments | $0 |
| Coinsurance | $2,200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$4,000** |

## Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,800 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**

Primary care provider office visits (*including chronic condition education)*
Diagnostic test *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| | |
|---|---|
| **Total Example Cost** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,800 |
| Copayments | $144 |
| Coinsurance | $1091.20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$3,035.20** |

## Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

| | |
|---|---|
| The plan's overall deductible | $1,800 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**

Emergency room care *(including medical supplies)*
Diagnostic test *(X-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| | |
|---|---|
| **Total Example Cost** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,800 |
| Copayments | $50 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,860** |