# CITY OF GULFPORT: Medical Plan Option II

**Coverage Period: Beginning on or after 1/1/2016**

**Summary of Benefits and Coverage:** What this Plan Covers and What it Costs **Coverage for:** All Coverage Types **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 www.selectadministrativeservices.com or by calling 1-800-847-6621.

| Important Questions | Answers | | Why this Matters: |
|---|---|---|---|
| **What is the overall deductible?** | **In-Network:**<br>Individual: **$1,000**<br>Family**: $3,000** | **Out-of-Network:**<br>Individual: **$2,000**<br>Family: **$6,000** | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document/SPD 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**. |
| | Does not apply to copayments, hearing aid benefits, weight loss surgery and amounts in excess of UCR | | |
| **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?** | **In-Network:**<br>Individual: **$6,600**<br>Family: **$13,200** | | The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Weight loss surgery copayment of $2,000, balance-billed charges, health care this plan doesn't cover, and pre-authorization penalties. | | 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 In-Network providers see www.selectadministrativeservices.com or call 1-800-847-6621. | | The plan treats **providers** the same in determining payment for the same services. |
| **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. | | Some of the services this plan doesn't cover are listed below (see Excluded Services & Other Covered Services). See your plan document/SPD for additional information about **excluded services**. |

**Questions:** Call 1-800-847-6621 or visit us at www.selectadministrativeservices.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.selectadministrativeservices.com or call 1-800-847-6621 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|

- **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 visit to treat an injury or illness | $40 copayment/visit | 50% coinsurance | |
| | Specialist visit | $40 copayment/visit | 50% coinsurance | |
| | Preventive care/screening/immunization | $0 | 50% coinsurance | Includes preventive services as defined by the Affordable Care Act. For a list of services visit https://www.healthcare.gov/what-are-my-preventive-care-benefits/ |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | Deductible does not apply for services in the office |

| 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 |
|---|---|---|---|---|
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.selectadmnistrativeservices.com | Category One drugs | $10 copayment / prescription (retail) | Not covered | Covers up to a 30-day supply (retail prescriptions) |
| | Category Two drugs | $20 copayment / prescription (retail) | Not covered | |
| | Category Three drugs | $35 copayment / prescription (retail) | Not covered | |
| | Category Four drugs | $100 copayment / prescription | Not covered | |
| | Category One Maintenance drugs | $25 copayment / prescription | Not covered | Limited to a 90-day supply thru mail-order service. |
| | Category Two Maintenance drugs | $50 copayment / prescription | Not covered | |
| | Category Three Maintenance drugs | $85 copayment/ prescription | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | Weight Loss surgery is limited to a lifetime maximum benefit of $20,000 including a $2,000 copayment per member. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room services | $125 Co-Payment, then 20% coinsurance after deductible | $125 Co-Payment, then 20% coinsurance after deductible | Copayment waived if admitted. |

| 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 |
|---|---|---|---|---|
| | Emergency medical transportation | 20% coinsurance, after deductible | 20% coinsurance, after deductible | Includes emergency air transportation. Paid at in-network level if true emergency. |
| | Urgent care | 20% coinsurance, after deductible | 50% coinsurance, after deductible | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance, after deductible | 50% coinsurance, after deductible | Precertification required. |
| | Physician/surgeon fee | 20% coinsurance, after deductible | $750 Co-Payment, then 50% coinsurance after deductible | Precertification required. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Office visit- $40 co-payment Facility services-20% coinsurance after deductible | 50% coinsurance, after deductible | |
| | Mental/Behavioral health inpatient services | 20% coinsurance, after deductible | $750 Co-Payment, then 50% coinsurance after deductible | Precertification required. |
| | Substance use disorder outpatient services | Office visit- $40 co-payment Facility services-20% coinsurance after deductible | 50% coinsurance, after deductible | |
| | Substance use disorder inpatient services | 20% coinsurance, after deductible | $750 Co-Payment, then 50% coinsurance after deductible | Precertification required. |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance, after deductible | 50% coinsurance, after deductible | Coverage for employee and spouse only. |
| | Delivery and all inpatient services | 20% coinsurance, after deductible | 50% coinsurance, after deductible | Precertification required for extended stay. |

| 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 need help recovering or have other special health needs** | Home health care | 20% coinsurance, after deductible | 50% coinsurance, after deductible | Precertification required. Limited to 100 visits per year. |
| | Rehabilitation services | 20% coinsurance, after deductible | 50% coinsurance, after deductible | Check with plan for limitations that may apply based on type of therapy. Therapies Included: cardiac rehabilitation, occupational, physical, pulmonary/ respiratory, speech. |
| **If your child needs dental or eye care** | Habilitation services | Not covered | Not covered | |
| | Skilled nursing care | 20% coinsurance, after deductible | 50% coinsurance, after deductible | Limited to 90 days per year. |
| | Durable medical equipment | 20% coinsurance, after deductible | 50% coinsurance, after deductible | Durable medical equipment includes medical supplies. |
| | Hospice service | 20% coinsurance, after deductible | 50% coinsurance, after deductible | Lifetime limit of $10,000. |
| | 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 (for rehabilitation purposes)
- Cosmetic surgery
- Dental care (Adult)
- Dental check (Child)
- Glasses
- Habilitation services
- Routine Eye Care
- Routine Foot Care
- Weight loss programs
- Long-term Care
- Most Coverage Provided Outside the U.S.
- Non-Emergency Care while Traveling outside the U.S.

**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
- Hearing Aids
- Private Duty Nursing
- Infertility Treatment (for diagnosis only)

## 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 1-800-847-6621. 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 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 a plan representative at 1-800-847-6621 or visit us at www.selectadministrativeservices.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may be available in your state to help you with your appeal. Visit www.dol.gov/ebsa/healthreform. Under "Internal Claims and Appeals and External Review", select *Consumer Assistance Programs* for contact information of those states currently offering programs to assist consumers in filing an appeal.

## 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** $4,280
- **Patient pays** $3,260

**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 | $1,900 |
| Copays | $60 |
| Coinsurance | $1,000 |
| Limits or exclusions | $300 |
| **Total** | **$3,260** |

These amounts assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not notified the plan, your costs may be higher. For more information, contact 1-800-847-6621 or visit us at www.selectadministrativeservices.com.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,170
- **Patient pays** $1,230

**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 | $0 |
| Copays | $1200 |
| Coinsurance | $30 |
| Limits or exclusions | $0 |
| **Total** | **$1,230** |

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 1-800-847-6621 or visit us at www.selectadministrativeservices.com.

# 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.