CITY OF JACKSON EMPLOYEE & RETIREE MEDICAL BENEFIT PLAN

Coverage Period: 1/1/2014 - 12/31/2014

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 www.bcbsms.com or by calling 1-800-222-8046. You may also contact the Department of Personnel Management/Insurance at 601-960-1051 or 601-960-2288.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$400 for Individuals. $1,200 for Families. Doesn't apply to preventive care.	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. $50 for prescriptions. 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.
Is there an out–of–pocket limit on my expenses?	Yes. $5,000 for Individuals.	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?	Balance-billed charges, co-payments, deductibles, outpatient treatment for mental/behavioral health and substance use disorders, premiums, TMJ benefits, and healthcare this plan doesn't cover.	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. See www.bcbsms.com or call 1-800-222-8046 for a list of Network Providers	If you use an in-network doctor or other healthcare 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 don't need a referral to see a specialist.	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 on page 6. See your policy or plan document for additional information about excluded services.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered healthcare, 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 Network Providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$20 /visit	25% Co-insurance	Other Covered Services that are performed in the Network Provider's office and Covered Services performed by Network Physician Assistants or Network Nurse Mid-wives will be subject to the Network Coinsurance level.
	Specialist visit	$30 /visit	25% Co-insurance	Other Covered Services that are preformed in the Network Provider's office will be subject to the Network Co-insurance level.
	Other practitioner office visit	$30 /visit to Podiatrist; 25% Co-insurance for other Allied Providers	25% Co-insurance	Other Covered Services that are preformed in the Network Provider's office will be subject to the Network Co-insurance level. Physical medicine subject to limit of 20 visits per year. Routine vision and podiatry are not covered. Chiropractic Care has a $75 maximum allowable charge and is limited to 12 visits per year.
	Preventive care/screening/immunization	$20/visit; No charge for Mammography, PSA Test, Childhood Immunization and Colonoscopy.	Not covered	Services must be rendered by a Primary Care Provider in that Provider's clinical setting and according to the Preventive Health Services Age and Gender Guidelines for the covered services. Age and visit limits may apply.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	25% Co-insurance	25% Co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	25% Co-insurance	25% Co-insurance	——————none——————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsms.com.	Generic	$10/prescription	$20/prescription	Limited to a 30 day supply
	Preferred Brand	$25/prescription	$50/prescription	
	Non-Preferred Brand	$50/prescription	$100/prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% Co-insurance	35% Co-insurance	——————none——————
	Physician/surgeon fees	25% Co-insurance	25% Co-insurance	——————none——————
If you need immediate medical attention	Emergency room services	25% Co-insurance	25% Co-insurance	Your cost if you use a Non-Network Provider for non-emergency services will be 35%.
	Emergency medical transportation	25% Co-insurance	25% Co-insurance	——————none——————
	Urgent care	$20/primary care visit; $30/specialist visit	25% Co-insurance	Other Covered Services that are performed in the Network Provider's office and Covered Services performed by Network Physician Assistants or Network Nurse Mid-wives will be subject to the Network Coinsurance level.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% Co-insurance	35% Co-insurance	Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from non-network provider. After out-of-pocket is met, your cost to use a Non-Network Provider is 10% Co-insurance.
	Physician/surgeon fee	25% Co-insurance	25% Co-insurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% Co-insurance	50% Co-insurance	Prior authorization required. Physician office visits and outpatient hospital visits limited to a combined 52 visits per year. When services are pre-certified and managed by the employee assistance program coordinator, your cost will be 25% Co-insurance.
	Mental/Behavioral health inpatient services	25% Co-insurance	Inpatient: 25% Co-insurance. Partial hospitalization: 35% Co-insurance.	Prior authorization required. Limited to 30 inpatient days per year. Partial hospitalization limited to 60 days per year. After out-of-pocket is met, your cost to use a Non-Network Provider is 10% Co-insurance for inpatient and partial hospitalization services.
	Substance use disorder outpatient services	50% Co-insurance	50% Co-insurance	Prior authorization required. Physician office visits and outpatient hospital visits limited to a combined 52 visits per year. When services are pre-certified and managed by the employee assistance program coordinator, your cost will be 25% Co-insurance.
	Substance use disorder inpatient services	25% Co-insurance	Inpatient: 25% Co-insurance. Partial hospitalization: 35% Co-insurance.	Prior authorization required. Limited to 30 inpatient days per year. Partial hospitalization limited to 60 days per year. After out-of-pocket is met, your cost to use a Non-Network Provider is 10% Co-insurance for inpatient and partial hospitalization services.
If you are pregnant	Prenatal and postnatal care	25% Co-insurance	25% Co-insurance	Maternity coverage is not available for dependent children.
	Delivery and all inpatient services	25% Co-insurance	35% Co-insurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	25% Co-insurance	25% Co-insurance	Limited to 30 days per year.
	Rehabilitation services	25% Co-insurance	Inpatient rehabilitation: 35% Co-insurance; Speech, Physical and Occupational Therapy: 25% Co-insurance	Inpatient Rehabilitation limited to 30 days per year by Network Provider. After out-of-pocket is met, your cost to use a Non-Network Provider is 10% Co-insurance for inpatient rehabilitation. Physical Medicine limited to 20 visits per year. Outpatient Cardiac Rehab limited to 36 visits per year and must be rendered by Network Provider. Speech Therapy limited to 20 outpatient visits per year and not available for learning or developmental disabilities.
	Habilitation services	Not covered	Not covered	Habilitation services are not available.
	Skilled nursing care	Not covered	Not covered	——————none——————
	Durable medical equipment	25% Co-insurance	35% Co-insurance	——————none——————
	Hospice service	25% Co-insurance	25% Co-insurance	30 day lifetime limitation
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Routine dental and eye care are not available.
	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 • Bariatric Surgery • Cosmetic Surgery • Dental Care • Habilitation Services	• Hearing Aids • Infertility Treatment • Long-term Care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine Eye Care • Routine Foot Care • Weight Loss Programs

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.)
• Chiropractic Care

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 601-960-1051. 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: the plan at 601-960-1051, Blue Cross & Blue Shield of Mississippi at 1-800-222-8046 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

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 is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al1-800-222-8046.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-222-8046.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-222-8046.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'1-800-222-8046.

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 $5,260
- Patient pays $2,280

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	$420
Co-pays	$0
Coinsurance	$1,710
Limits or exclusions	$150
Total	$2,280

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

- Amount owed to providers: $5,400
- Plan pays $3,810
- Patient pays $1,590

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	$450
Co-pays	$520
Coinsurance	$250
Limits or exclusions	$370
Total	$1,590

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.