Magellan Health Services: Basic Plan

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

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

Coverage for: Members | **Plan Type:** HSA

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.MyHealthToolKitCF.com or by calling 1-855-229-5719.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: $3,000 single contract / $6,000 family contract. Out-of-network: $6,000 single contract / $12,000 family contract. Medical, Pharmacy and Behavioral health costs apply to 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?	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?	In-network: $6,200 per person / $12,400 family. Out-of-network: $12,400 per person / $24,800 family annually.	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, penalties for failure to obtain pre-authorization 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. For a list of preferred providers, see www.myhealthtoolkitcf.com or call 1-800-810-2583.	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.	Some of the services this plan doesn't cover are listed in the Excluded Services and Other Covered Services section. See your policy or plan document for additional information about excluded services.

- 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 in-network 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	20% Coinsurance	40% Coinsurance	None
	Specialist visit	20% Coinsurance	40% Coinsurance	None
	Other practitioner office visit	20% Coinsurance	40% Coinsurance	See medical plan document. Limited to 30 visits per calendar year for chiropractor visits.
	Preventive care/screening/immunization	No Charge	40% Coinsurance	Routine physicals covered beginning age 18. See your Employer about other benefits or www.healthcare.gov for Preventive care guidelines.
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	Pre-authorization is required. Member penalty for not obtaining pre-authorization is denial of all charges.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at https://mhs.magellanpharmacysolutions.com/	Generic drugs	$15 co-pay retail / $30 co-pay mail order	Not Covered	Deductible applies first. See plan document for limitations.
	Preferred brand drugs	$35 co-pay retail / $65 co-pay mail order	Not Covered	Deductible applies first. See plan document for limitations.
	Non-preferred brand drugs	15% coinsurance retail / 15% coinsurance mail order	Not Covered	Deductible applies first. $55 min/$175 max for retail $105 min/$325 max for mail order
	Specialty drugs	Copay/Coinsurance applies	Not Covered	Deductible applies first. Co-pay /Coinsurance may vary by drug type.
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	20% Coinsurance	If nonemergency, member is responsible for 20% coinsurance in-network, and 40% coinsurance out-of-network.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	20% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Pre-authorization is required. Member penalty for not obtaining pre-authorization is 20% of allowed amount.
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	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
If you have mental health, behavioral health, or substance abuse needs More information about mental health coverage is available at www.magellanhealth.com/member	Mental/Behavioral health outpatient services	20% Coinsurance	40% Coinsurance	Pre-certification is required for all psychological testing and electroconvulsive treatment (ECT). Please contact Magellan LifeResources at 1-866-266-2376 prior to receiving care.
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	Pre-certification is required. Please contact Magellan LifeResources at 1-866-266-2376 prior to receiving care.
	Substance use disorder outpatient services	20% Coinsurance	40% Coinsurance	Pre-certification is required for all psychological testing and electroconvulsive treatment (ECT). Please contact Magellan LifeResources at 1-866-266-2376 prior to receiving care.
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	Pre-certification is required. Please contact Magellan LifeResources at 1-866-266-2376 prior to receiving care.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	40% Coinsurance	Applies on initial visit. All subsequent professional claims pay 100% no deductible. See plan document for details.
	Delivery and all inpatient services	20% Coinsurance	40% Coinsurance	Pre-authorization is required. Member penalty for not obtaining pre-authorization is 20% of allowed amount.

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	40% Coinsurance	Home healthcare services are limited to 120 visits per member per benefit year. Pre-authorization is required. Member penalty for not obtaining pre-authorization is denial of all charges.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	Cardiac rehabilitation is limited to 36 days per member per benefit year. Physical, occupational and speech therapy limited to 60 visits per calendar year. Other restrictions may apply; see medical plan document.
	Habilitation services	20% Coinsurance	40% Coinsurance	Other restrictions may apply; see medical plan document.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Skilled Nursing Care is limited to 120 days per member per benefit period. Pre-authorization is required. Member penalty for not obtaining pre-authorization is 20% of allowed amount.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	None
	Hospice service	20% Coinsurance	40% Coinsurance	Hospice services are limited to a $10,000 lifetime maximum per member. Pre-authorization is required. Member penalty for not obtaining pre-authorization is 20% of allowed amount
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	See your Employer for benefit details.
	Glasses	Not Covered	Not Covered	See your Employer for benefit details.
	Dental check-up	Not Covered	Not Covered	See your Employer for benefit details.

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.)

- Cosmetic Surgery
- Dental Care (adults)
- Weight Loss Programs
- Infertility treatment
- Long Term Care
- Routine Eye Care (adults)
- Routine Foot Care

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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Non-emergency care when traveling outside the U.S. See www.myhealthtoolkitcf.com
- Private Duty Nursing (only when associated with home health 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 1-855-229-5719. 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: the plan at 1-855-229-5719, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) www.dol.gov/ebsa/healthreform, or the Department of Managed Health Care at 1-888-466-2219. Additionally, a consumer assistance program can help you file your appeal. Contact Missouri Department of Insurance, 301 W. High Street, Room 830, Harry S. Truman State Building, Jefferson City, MO 65101. 800-726-7390. www.insurance.mo.gov. consumeraffairs@insurance.mo.gov.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-229-5719

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-229-5719

Chinese (中文): 如果需要中文的帮助, **请拨打这个号码**1-855-229-5719

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-229-5719

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** $3,520
- **Patient pays** $4,020

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	$3,000
Copays	$20
Coinsurance	$850
Limits or exclusions	$150
Total	$4,020

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,830
- **Patient pays** $3,570

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	$3,000
Copays	$300
Coinsurance	$190
Limits or exclusions	$80
Total	$3,570

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.