Blue Cross & Blue Shield of Mississippi: Blue Care for Kids

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

Coverage Period: 01/01/2017 - 12/31/2017
Coverage for: Individual | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the Certificate of Coverage for the plan by clicking here or by calling 601-664-4590 or 1-800-942-0278.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$7,150** for Network Providers. **$14,300** for Non-Network Providers. Deductible is waived for preventive care, pediatric dental check-ups and pediatric eye exams. The Network Deductible and Out-of-Pocket are the same amount. Once $7,150 is paid, there will be no charge for Covered Services performed by Network Providers.	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 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?	Yes. For Network Providers **$7,150**.	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 healthcare expenses.
What is not included in the out–of–pocket limit?	Balance-billed charges, non-network deductible, non-network co-insurance, premiums, 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 **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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **601-664-4590 or 1-800-942-0278** or visit us at **www.bcbsms.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.cciio.cms.gov** or call **601-664-4590 or 1-800-942-0278** to request a copy.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered healthcare, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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**, **co-payments** and **co-insurance** 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% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	——————none——————
	Specialist visit	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	
	Other practitioner office visit	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance; Physical Medicine: Not covered	Routine vision and podiatry are not covered. See Rehabilitation services and Habilitation services, below, for additional information.
	Preventive care/ screening/immunization	No charge	Not covered	Services must be rendered by a *Healthy You!* Network Provider in that Provider's setting. Covered Services are based upon age and gender guidelines and must be included in the Grade A and B recommendations of the U.S. Preventive Services Task Force.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance. No charge after out-of-pocket is met.	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance. No charge after out-of-pocket is met.	Not covered	

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsms.com	Category One drugs	20% / prescription then no charge after out-of-pocket is met.	Not covered	Deductible is waived for Category One drugs. Limited to a 30-day supply. Certain drugs may be subject to Prior Authorization, quantity limits, and/or duration of use restrictions. Generic drugs mandatory when available.
	Category Two drugs	20% coinsurance. No charge after out-of-pocket is met.	Not covered	
	Category Three drugs	20% coinsurance. No charge after out-of-pocket is met.	Not covered	
	Category Four drugs	20% coinsurance. No charge after out-of-pocket is met.	Not covered	
	Category One Maintenance drugs	20% / prescription then no charge after out-of-pocket is met.	Not covered	Deductible is waived for Category One drugs. Limited to a 90-day supply. Certain drugs may be subject to Prior Authorization, quantity limits, and/or duration of use restrictions. Generic drugs mandatory when available.
	Category Two Maintenance drugs	20% coinsurance. No charge after out-of-pocket is met.	Not covered	
	Category Three Maintenance drugs	20% coinsurance. No charge after out-of-pocket is met.	Not covered	
	Category Four Maintenance drugs	20% coinsurance. No charge after out-of-pocket is met.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	Prior Authorization may be required if Covered Services can be provided in a lower place of treatment.
	Physician/surgeon fees	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance. No charge after out-of-pocket is met.	20% coinsurance. No charge after out-of-pocket is met.	Your cost if you use a non-network provider for non-emergency services will be 50%.
	Emergency medical transportation	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	——————none——————
	Urgent care	20% coinsurance. No charge after out-of-pocket is met.	50% 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 a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from non-network provider. Prior Authorization may be required if Covered Services can be provided in a lower place of treatment.
	Physician/surgeon fee	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	Subject to Care Management, Medical Necessity, and appropriateness of care.
	Mental/Behavioral health inpatient services	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	
	Substance use disorder outpatient services	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	
	Substance use disorder inpatient services	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	Coverage for newborn well baby care is available to a newborn through a Blue Care for Kids policy issued to the newborn.
	Delivery and all inpatient services	20% coinsurance. No charge after out-of-pocket is met.	50% co-insurance	
If you need help recovering or have other special health needs	Home healthcare	20% coinsurance. No charge after out-of-pocket is met.	Not covered	Available only through Care Management.
	Rehabilitation services	20% coinsurance. No charge after out-of-pocket is met.	Inpatient: Not covered; Outpatient: 50% co-insurance; Physical Medicine: Not covered	Limited to 30 Inpatient days per year. Physical medicine limited to 20 combined outpatient visits per year in the home and provider's office. Outpatient Cardiac Rehab limited to 36 visits per year by a Network Provider. Speech Therapy limited to 20 visits per year and not available for learning or developmental disabilities which do not qualify for Habilitative Care.

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
	Habilitation services	20% coinsurance. No charge after out-of-pocket is met.	Not covered	Limited to 20 Physical Therapy and Occupational Therapy visits, combined, and 20 Speech Therapy Visits.
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	20% coinsurance. No charge after out-of-pocket is met.	Not covered	Medical necessity certificate required.
	Hospice service	20% coinsurance. No charge after out-of-pocket is met.	Not covered	6 month lifetime limitation
If your child needs dental or eye care	Eye exam	20% coinsurance then no charge after out-of-pocket is met.	Not covered	Limited to one exam per year. Deductible is waived.
	Glasses	The difference between the **allowed amount** and the cost of the glasses.	Not covered	Limited to one pair up to a maximum of $150 per year.
	Dental check-up	20% coinsurance then no charge after out-of-pocket is met.	20% coinsurance	Limited to one check-up every six months. Deductible is waived for Network Provider.

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
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care;
- Skilled nursing care; and
- 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
- Dental care
- Routine eye care

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the plan at 601-664-4590 or 1-800-942-0278. 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: Blue Cross & Blue Shield of Mississippi at 601-664-4590 or 1-800-942-0278 or the Mississippi Insurance Department at 1-800-562-2957.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have healthcare 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** $240
- **Patient pays** $7,300

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	$7,150
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$150
Total	**$7,300**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,920
- **Patient pays** $2,480

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	**$4,100**

Patient pays:

Deductibles	$1,550
Co-pays	$0
Co-insurance	$710
Limits or exclusions	$220
Total	**$2,480**

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 pre-existing 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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.