



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.

| Important Questions | Answers | Why this Matters: |
|---|---|--|
| What is the overall <u>deductible</u> ? | \$5,000 for Network Providers. \$10,000 for Non-Network Providers. Doesn't apply to preventive care. | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | No. There are no other specific <u>deductibles</u> . | 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 <u>out-of-pocket limit</u> on my expenses? | Yes. For Network Providers: \$6,550 | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ? | 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 <u>out-of-pocket limit</u> . |
| 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a <u>network of providers</u> ? | 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their network. See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u> ? | No. You don't need a referral to see a specialist. | You can see the <u>specialist</u> 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 <u>excluded services</u> . |

Questions: Call 1-800-222-8046 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.

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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 <u>healthcare provider's office or clinic</u> | Primary care visit to treat an injury or illness | 20% co-insurance | 50% co-insurance | -----none----- |
| | Specialist visit | 20% co-insurance | 50% co-insurance | |
| | Other practitioner office visit | 20% co-insurance | 50% co-insurance; Physical Medicine: Not covered | Physical medicine subject to a combined limit of 20 visits per year in the home and provider's office. Routine vision and podiatry are not covered. |
| | Preventive care/screening/immunization | No charge | Not covered | Services must be rendered by a <i>Healthy You!</i> 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% co-insurance | Not covered | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 20% co-insurance | 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 |
|--|--|---|---|--|
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.bcbsms.com.</p> | Category One drugs | 20% co-insurance | Not covered | Limited to a 30-day supply |
| | Category Two drugs | 20% co-insurance | Not covered | |
| | Category Three drugs | 20% co-insurance | Not covered | |
| | Category Four drugs | 20% co-insurance | Not covered | |
| | Category One Maintenance drugs | 20% co-insurance | Not covered | Limited to a 90-day supply. |
| | Category Two Maintenance drugs | 20% co-insurance | Not covered | |
| | Category Three Maintenance drugs | 20% co-insurance | Not covered | |
| | Category Four Maintenance drugs | 20% co-insurance | Not covered | |
| <p>If you have outpatient surgery</p> | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance | 50% co-insurance | -----none----- |
| | Physician/surgeon fees | 20% co-insurance | 50% co-insurance | -----none----- |
| <p>If you need immediate medical attention</p> | Emergency room services | 20% co-insurance | 20% co-insurance | Your cost if you use a non-network provider for non-emergency services will be 50% co-insurance. |
| | Emergency medical transportation | 20% co-insurance | 50% co-insurance | -----none----- |
| | Urgent care | 20% co-insurance | 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% co-insurance | 50% co-insurance | Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from non-network provider. |
| | Physician/surgeon fee | 20% co-insurance | 50% co-insurance | -----none----- |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 20% co-insurance | 50% co-insurance | Subject to Care Management. |
| | Mental/Behavioral health inpatient services | 20% co-insurance | 50% co-insurance | Subject to Care Management. |
| | Substance use disorder outpatient services | 20% co-insurance | 50% co-insurance | Subject to Care Management. |
| | Substance use disorder inpatient services | 20% co-insurance | 50% co-insurance | Subject to Care Management. |
| If you are pregnant | Prenatal and postnatal care | 20% co-insurance | 50% co-insurance | -----none----- |
| | Delivery and all inpatient services | 20% co-insurance | 50% 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 healthcare | 20% co-insurance | Not covered | Available only through Care Management. |
| | Rehabilitation services | Inpatient and Outpatient: 20% co-insurance | Inpatient: Not covered; Outpatient: 50% co-insurance; Physical Medicine: Not covered | Inpatient Rehabilitation limited to 30 days per year by Network Provider. 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 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 | 20% co-insurance | 50% co-insurance | Limited to Rehabilitation services. |
| | Skilled nursing care | Not covered | Not covered | -----none----- |
| | Durable medical equipment | 20% co-insurance | Not covered | -----none----- |
| | Hospice service | 20% co-insurance | Not covered | 6 month lifetime limitation |
| If your child needs dental or eye care | Eye exam | 20% co-insurance | Not covered | Limited to one exam per year. |
| | Glasses | The difference between the <u>allowed amount</u> and the cost of the glasses. | Not covered | Limited to one pair up to a maximum of \$150 per year. |
| | Dental check-up | 20% co-insurance | 20% co-insurance | Limited to one check-up every six months. |

Excluded Services & Other Covered Services:

| | | |
|--|---|--|
| <p>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)</p> | | |
| <ul style="list-style-type: none"> Acupuncture Bariatric Surgery Cosmetic Surgery Dental Care for Adults Hearing Aids | <ul style="list-style-type: none"> Infertility Treatment Long-term Care Non-emergency care when traveling outside the U.S. Private-duty Nursing | <ul style="list-style-type: none"> Routine Eye Care for Adults Routine Foot Care Skilled Nursing Care Weight Loss Programs |
| <p>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.)</p> | | |
| <ul style="list-style-type: none"> Chiropractic 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 1-800-222-8046. 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, Blue Cross & Blue Shield of Mississippi at 1-800-222-8046 or the Mississippi Department of Insurance at 1-800-562-2957.

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 al 1-800-222-8046.

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, kwijigo 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 \$1,930
- Patient pays \$5,610

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 | \$5,000 |
| Co-pays | \$0 |
| Co-insurance | \$460 |
| Limits or exclusions | \$150 |
| Total | \$5,610 |

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 | \$5,400 |

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.

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