



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, you can get the Certificate of Coverage by clicking [here](#) or call 601-664-4590 or 1-800-942-0278. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [co-insurance](#), [co-payment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 601-664-4590 or 1-800-942-0278 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network</a> : \$5,000 per Individual / \$10,000 per Family. <a href="#">Non-Network</a> : \$10,000 per Individuals / \$20,000 per Family.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">co-payment</a> or <a href="#">co-insurance</a> may apply. For example, this plan covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">Network Providers</a> : \$7,350 per Individual / \$14,700 per Family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Balance-billed charges, <a href="#">non-network deductibles</a> , <a href="#">non-network co-insurance</a> , <a href="#">premiums</a> and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcbsms.com">www.bcbsms.com</a> or call 601-664-4590 or 1-800-942-0278 for a list of <a href="#">Network Providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a provider in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [co-payment](#) and [co-insurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	<a href="#">Primary</a> care visit to treat an injury or illness	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	None.
	<a href="#">Specialist</a> visit	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	Routine vision is not covered for adults. Routine podiatry is not covered. See <a href="#">Rehabilitation services</a> and <a href="#">Habilitation services</a> , below, for additional information.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	Covered Services must be rendered by a <i>Healthy You!</i> Network Provider in that provider's setting. Please see <a href="http://www.bcbsms.com/be-healthy/healthy-you-wellness-benefit">www.bcbsms.com/be-healthy/healthy-you-wellness-benefit</a> . You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">Provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% <a href="#">Co-insurance</a>	Not covered	Benefits listed are for Independent Labs. Services provided in the <a href="#">Provider's</a> office may be subject to the amounts listed above for <a href="#">Primary</a> or <a href="#">Specialist</a> care.
	Imaging (CT/PET scans, MRIs)	40% <a href="#">Co-insurance</a>	Not covered	None.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsms.com">www.bcbsms.com</a>	Category One Drugs	\$10 /prescription	Not covered	Limited to a 30-day retail supply. Certain Prescription drugs may be subject to Prior Authorization, quantity limits, day limits and/or duration of use restrictions. Generic drugs mandatory when available. * See Prescription Drug Benefits section of Article VIII.
	Category Two Drugs	40% <a href="#">Co-insurance</a>	Not covered	
	Category Three Drugs	40% <a href="#">Co-insurance</a>	Not covered	
	Category Four Drugs	40% <a href="#">Co-insurance</a>	Not covered	Prescription <a href="#">Deductible</a> is waived for Category One drugs.

\* For more information about limitations and exceptions, see the [plan](#) or policy document on the Member page at [www.bcbsms.com](http://www.bcbsms.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Category One Maintenance Drugs	40% <a href="#">Co-insurance</a>	Not covered	Limited to a 90-day maintenance supply. Certain drugs may be subject to Prior Authorization, quantity limits, day limits and/or duration of use restrictions. Generic drugs mandatory when available. *See Prescription Drug Benefits section.
	Category Two Maintenance Drugs	40% <a href="#">Co-insurance</a>	Not covered	
	Category Three Maintenance Drugs	40% <a href="#">Co-insurance</a>	Not covered	
	Category Four Maintenance Drugs	40% <a href="#">Co-insurance</a>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	Prior Authorization may be required if Covered Services can be provided in a lower place of treatment.
	Physician/surgeon fees	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">Co-insurance</a>	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a> for non-emergency services rendered by a <a href="#">Non-Network Provider</a> .
	<a href="#">Emergency medical transportation</a>	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	None.
	<a href="#">Urgent care</a>	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from <a href="#">Non-Network Provider</a> . Prior Authorization may be required if Covered Services can be provided in a lower place of treatment. *See Hospital Benefits Article.
	Physician/surgeon fees	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	Subject to Care Management, Medical Necessity, and appropriateness of care.
	Inpatient services	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document on the Member page at [www.bcbsms.com](http://www.bcbsms.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">Co-insurance</a> , or <a href="#">Deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	
	Childbirth/delivery facility services	40% <a href="#">Co-insurance</a>	50% <a href="#">Co-insurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	40% <a href="#">Co-insurance</a>	Not covered	Available only through Care Management.
	<a href="#">Rehabilitation services</a>	Inpatient and Outpatient: 40% <a href="#">Co-insurance</a>	Inpatient: Not covered; Outpatient: 50% <a href="#">Co-insurance</a> ; Physical Medicine: Not covered	Inpatient Rehabilitation limited to 30 days per year by a <a href="#">Network Provider</a> . Physical medicine limited to 20 combined outpatient visits per year in the home and <a href="#">Provider's</a> office. Outpatient Cardiac Rehab limited to 36 visits per year and must be rendered by a <a href="#">Network Provider</a> . Speech Therapy limited to 20 outpatient visits per year and not available for learning disabilities or developmental problems which do not qualify for <a href="#">Habilitation services</a> . *See Inpatient Rehabilitation, Outpatient Cardiac Rehabilitation, Physical Medicine and Speech Therapy sections.
	<a href="#">Habilitation services</a>	40% <a href="#">Co-insurance</a>	Not covered	Limited to 20 Physical Therapy and Occupational Therapy visits, combined, and 20 Speech Therapy visits.
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	Not covered.
	<a href="#">Durable medical equipment</a>	40% <a href="#">Co-insurance</a>	Not covered	Medical Necessity certificate required. *See Durable Medical Equipment section.
	<a href="#">Hospice services</a>	40% <a href="#">Co-insurance</a>	Not covered	6 month lifetime limitation.
If your child needs dental or eye care	Children's eye exam	40% <a href="#">Co-insurance</a>	Not covered	Limited to one exam per year. Limited to children under 19 years of age. <a href="#">Deductible</a> does not apply.
	Children's glasses	The difference between the <a href="#">allowed amount</a> and the cost of the glasses.	Not covered	Limited to one pair up to a maximum of \$150 per year. Limited to children under 19 years of age. <a href="#">Deductible</a> does not apply.
	Children's dental check-up	40% <a href="#">Co-insurance</a>	40% <a href="#">Co-insurance</a>	Limited to one check-up every six months. Limited to children under 19 years of age. <a href="#">Deductible</a> does not apply.

\* For more information about limitations and exceptions, see the [plan](#) or policy document on the Member page at [www.bcbsms.com](http://www.bcbsms.com).

### Excluded Services & Other Covered Services:

#### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- |                       |  |                            |
|-----------------------|--|----------------------------|
| • Acupuncture         | • Hearing Aids                                       | • Routine Eye Care (Adult) |
| • Bariatric Surgery   | • Infertility Treatment                              | • Routine Foot Care        |
| • Cosmetic Surgery    | • Long-term Care                                     | • Skilled Nursing Care     |
| • Dental Care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight Loss Programs     |
|                       | • Private-duty Nursing                               |                            |

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |  |   |
|--|---|
| • Chiropractic Care  | • Habilitation Services   |
| • Dental Care (Limited to children under 19 years of age.) | • Routine Eye Care (Limited to children under 19 years of age.) |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or you can contact the plan. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the plan, Blue Cross & Blue Shield of Mississippi at 601-664-4590 or 1-800-942-0278, the Mississippi Insurance Department at 1-800-562-2957, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**Does this plan provide Minimum Essential Coverage?** Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards?** Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 601-664-4590 or 1-800-942-0278.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 601-664-4590 or 1-800-942-0278.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 601-664-4590 or 1-800-942-0278.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 601-664-4590 or 1-800-942-0278.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$5,000
- [Primary co-insurance](#) 40%
- [Hospital \(facility\) co-insurance](#) 40%
- [Other co-insurance](#) 40%

This EXAMPLE event includes services like:  
Specialist office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Co-payments	\$0
Co-insurance	\$2,350
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,410</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist co-insurance](#) 40%
- [Hospital \(facility\) co-insurance](#) 40%
- [Other co-insurance](#) 40%

This EXAMPLE event includes services like:  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$5,000
Co-payments	\$310
Co-insurance	\$531
<i>What isn't covered</i>	
Limits or exclusions	\$235
<b>The total Joe would pay is</b>	<b>\$6,076</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist co-insurance](#) 40%
- [Hospital \(facility\) co-insurance](#) 40%
- [Other co-insurance](#) 40%

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,747
Co-payments	\$0
Co-insurance	\$71
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,818</b>

\*Note: This plan may have other deductibles for specific services included in this coverage example. See the "Are there other deductibles for specific services?" row above for additional information. The [plan](#) would be responsible for the other costs of these EXAMPLE Covered Services.