
 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 calling 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 <u>deductible</u> ?	\$1,000 per Individual / \$2,000 per Family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and medical services with <u>co-payments</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>co-payment</u> or <u>co-insurance</u> may apply. For example, this plan covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . 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 <u>deductibles</u> for specific services?	Yes. \$50 for <u>prescription drug coverage</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>Network Providers</u> : \$3,000 per Individual / \$6,000 per Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Balance-billed charges</u> , <u>non-network deductibles</u> , <u>non-network co-insurance</u> , <u>premiums</u> 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> .
Will you pay less if you use a <u>network provider</u> ?	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 <u>Network Providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a provider in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 provider's office or clinic	<u>Primary</u> care visit to treat an injury or illness	\$25 / office visit; <u>Deductible</u> does not apply.	40% <u>Co-insurance</u>	Other Covered Services rendered in the <u>Network Provider's</u> office will be subject to the <u>Network Co-insurance</u> amount.
	<u>Specialist</u> visit	\$40 / office visit; <u>Deductible</u> does not apply.	40% <u>Co-insurance</u>	Other Covered Services rendered in the <u>Network Provider's</u> office will be subject to the <u>Network Co-insurance</u> amount. Routine vision and podiatry are not covered. See <u>Rehabilitation services</u> , below, for additional information.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	Covered Services must be rendered by a <u>Healthy You! Network Provider</u> in that <u>Provider's</u> 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 <u>preventive</u> . Ask your <u>Provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Co-insurance</u>	Not covered	Benefits listed are for Independent Labs and Diagnostic Services Facilities. Services provided in the <u>Provider's</u> office may be subject to the amounts listed above for <u>Primary</u> or <u>Specialist</u> care.
	Imaging (CT/PET scans, MRIs)	20% <u>Co-insurance</u>	Not covered	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> 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 the Prescription Drug Benefits section in Article VIII.
	Category Two Drugs	\$25 /prescription	Not covered	
	Category Three Drugs	\$50 /prescription	Not covered	
	Category Four Drugs	\$100 /prescription	Not covered	Prescription <u>Deductible</u> 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	\$25 / Generic prescription	\$30 / Brand prescription	<p>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 the Prescription Drug Benefits section in Article VIII.</p> <p>Prescription <u>Deductible</u> is waived for Category One drugs.</p>
	Category Two Maintenance Drugs	\$62.50 / Generic prescription	\$75 / Brand prescription	
	Category Three Maintenance Drugs	\$125 / Generic prescription	\$150 / Brand prescription	
	Category Four Maintenance Drugs	\$250 / Generic prescription	\$300 / Brand prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Co-insurance</u>	40% <u>Co-insurance</u>	<p>Certain Covered Services may be subject to the Specialty Services provisions. *See Schedule of Benefits-Specialty Services. Prior Authorization may be required if Covered Services can be provided in a lower place of treatment. *See Ambulatory Surgical Facility Services Article.</p> <p>None.</p>
	Physician/surgeon fees	20% <u>Co-insurance</u>	40% <u>Co-insurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>Co-insurance</u>	20% <u>Co-insurance</u>	<p>40% <u>Co-insurance</u> for non-emergency services rendered by a <u>Non-Network Provider</u>.</p> <p>None.</p> <p>Other Covered Services rendered in the <u>Network Provider's</u> office will be subject to the <u>Network Co-insurance</u> amount.</p>
	<u>Emergency medical transportation</u>	20% <u>Co-insurance</u>	40% <u>Co-insurance</u>	
	<u>Urgent care</u>	\$25 / primary care or \$40 / specialist office visit; <u>Deductible</u> does not apply.	40% <u>Co-insurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Co-insurance</u>	40% <u>Co-insurance</u>	<p>Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from <u>Non-Network Provider</u>. Certain Covered Services may be subject to the Specialty Services provisions. *See Schedule of Benefits-Specialty Services. Prior Authorization may be required if Covered Services can be provided in a lower place of treatment. *See Hospital Benefits Article.</p> <p>None.</p>
	Physician/surgeon fees	20% <u>Co-insurance</u>	40% <u>Co-insurance</u>	

\* 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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 / office visit; 20% <u>Co-insurance</u> for other outpatient services. <u>Deductible</u> does not apply.	40% <u>Co-insurance</u>	For Outpatient services, other Covered Services rendered in the <u>Network Provider's</u> office will be subject to the <u>Network Co-insurance</u> amount with the <u>Deductible</u> waived. Subject to Care Management, Medical Necessity, and appropriateness of care.
	Inpatient services	20% <u>Co-insurance</u>	40% <u>Co-insurance</u>	
If you are pregnant	Office visits	\$25 / office visit <u>Deductible</u> does not apply.	40% <u>Co-insurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <u>Co-payment</u> , <u>Co-insurance</u> , or <u>Deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Maternity coverage is not available for dependent children.
	Childbirth/delivery professional services	20% <u>Co-insurance</u>	40% <u>Co-insurance</u>	
	Childbirth/delivery facility services	20% <u>Co-insurance</u>	40% <u>Co-insurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Co-insurance</u>	Not covered	Available only through Care Management. *See Home Health section in Care Management.
	<u>Rehabilitation services</u>	Inpatient and Outpatient: 20% <u>Co-insurance</u>	Inpatient: Not covered; Outpatient: 40% <u>Co-insurance</u> ; Physical Medicine: Not covered	Inpatient Rehabilitation limited to 30 days per year by a <u>Network Provider</u> . Physical medicine limited to 20 combined outpatient visits per year in the home and <u>Provider's</u> office. Outpatient Cardiac Rehab limited to 36 visits per year and must be rendered by a <u>Network Provider</u> . Speech Therapy limited to 20 outpatient visits per year and not available for learning disabilities or developmental problems. *See Inpatient Rehabilitation, Outpatient Cardiac Rehabilitation, Physical Medicine and Speech Therapy sections.
	<u>Habilitation services</u>	Not covered	Not covered	Not covered.
	<u>Skilled nursing care</u>	Not covered	Not covered	Not covered.
	<u>Durable medical equipment</u>	20% <u>Co-insurance</u>	Not covered	Medical Necessity certificate required. *See Durable Medical Equipment section.
	<u>Hospice services</u>	20% <u>Co-insurance</u>	Not covered	6 month lifetime limitation. *See Hospice Care section.

\* 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 your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Routine dental and eye care are not available.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

**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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care</li> <li>• Habilitation Services</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids</li> <li>• Infertility Treatment</li> <li>• Long-term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Care</li> <li>• Routine Foot Care</li> <li>• Skilled Nursing Care</li> <li>• Weight Loss Programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
<ul style="list-style-type: none"> <li>• Chiropractic Care</li> </ul>

**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 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.

\* 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).

**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.*-----

SAMPLE



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 \$1,000
- Primary co-payment \$25
- Hospital (facility) co-insurance 20%
- Other co-insurance 20%

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	\$1,000
Co-payments	\$0
Co-insurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,060</b>

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

- The plan's overall deductible \$1,000
- Specialist co-payment \$40
- Hospital (facility) co-insurance 20%
- Other co-insurance 20%

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*	\$1,050
Co-payments	\$815
Co-insurance	\$208
<i>What isn't covered</i>	
Limits or exclusions	\$235
<b>The total Joe would pay is</b>	<b>\$2,308</b>

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

- The plan's overall deductible \$1,000
- Specialist co-payment \$40
- Hospital (facility) co-insurance 20%
- Other co-insurance 20%

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	\$1,000
Co-payments	\$120
Co-insurance	\$133
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,253</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.