

 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> ?	<u>Network</u> : \$6,000 <u>Non-Network</u> : \$12,000	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.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services 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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>Network Providers</u> : \$6,650	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Balance-billed</u> charges, <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 plan's <u>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 plan pays (balance billing). 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 <u>provider's</u> office or clinic	<u>Primary</u> care visit to treat an injury or illness	20% <u>Co-insurance</u>	50% <u>Co-insurance</u>	None.
	<u>Specialist</u> visit	20% <u>Co-insurance</u>	50% <u>Co-insurance</u>	Routine vision and podiatry are not covered. See <u>Rehabilitation services</u> , and <u>Habilitation 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 preventive. 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	20% <u>Co-insurance</u>	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.
	Category Two Drugs	20% <u>Co-insurance</u>	Not covered	
	Category Three Drugs	20% <u>Co-insurance</u>	Not covered	
	Category Four Drugs	20% <u>Co-insurance</u>	Not covered	

\* 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	20% <u>Co-insurance</u>	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	20% <u>Co-insurance</u>	Not covered	
	Category Three Maintenance Drugs	20% <u>Co-insurance</u>	Not covered	
	Category Four Maintenance Drugs	20% <u>Co-insurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Co-insurance</u>	50% <u>Co-insurance</u>	Certain Covered Services may be subject to Specialty Services. *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.
	Physician/surgeon fees	20% <u>Co-insurance</u>	50% <u>Co-insurance</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>Co-insurance</u>	20% <u>Co-insurance</u>	50% <u>Co-insurance</u> for non-emergency services rendered by a <u>Non-Network Provider</u> .
	<u>Emergency medical transportation</u>	20% <u>Co-insurance</u>	50% <u>Co-insurance</u>	None.
	<u>Urgent care</u>	20% <u>Co-insurance</u>	50% <u>Co-insurance</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Co-insurance</u>	50% <u>Co-insurance</u>	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 Specialty Services. *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.
	Physician/surgeon fees	20% <u>Co-insurance</u>	50% <u>Co-insurance</u>	None.

\* 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	20% <u>Co-insurance</u>	50% <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 with the <u>Deductible</u> waived. Subject to Care Management, Medical Necessity, and appropriateness of care.
	Inpatient services	20% <u>Co-insurance</u>	50% <u>Co-insurance</u>	
If you are pregnant	Office visits	20% <u>Co-insurance</u>	50% <u>Co-insurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>Co-insurance</u> , or a <u>Deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Coverage for newborn well baby care is available to a newborn through a Blue Care for Kids policy issued to the newborn.
	Childbirth/delivery professional services	20% <u>Co-insurance</u>	50% <u>Co-insurance</u>	
	Childbirth/delivery facility services	20% <u>Co-insurance</u>	50% <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: 50% <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 which do not qualify for <u>Habilitation services</u> . *See Inpatient Rehabilitation, Outpatient Cardiac Rehabilitation, Physical Medicine and Speech Therapy sections.
	<u>Habilitation services</u>	20% <u>Co-insurance</u>	Not covered	Limited to 20 Physical Therapy and Occupational Therapy visits, combined, and 20 Speech Therapy visits.
	<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> </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>	<ul style="list-style-type: none"> <li>• Habilitation Services</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 Mississippi Insurance Department at 1-800-562-2957 or you can contact the plan at 601-664-4590 or 1-800-942-0278. 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: 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 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.

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

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## 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 <u>plan's</u> overall <u>deductible</u>	\$6,000
■ <u>Primary co-insurance</u>	20%
■ <u>Hospital (facility) co-insurance</u>	20%
■ <u>Other co-insurance</u>	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	\$6,000
Co-payments	\$0
Co-insurance	\$650
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,710</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$6,000
■ <u>Specialist co-insurance</u>	20%
■ <u>Hospital (facility) co-insurance</u>	20%
■ <u>Other co-insurance</u>	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	\$6,000
Co-payments	\$0
Co-insurance	\$201
<i>What isn't covered</i>	
Limits or exclusions	\$235
<b>The total Joe would pay is</b>	<b>\$6,436</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$6,000
■ <u>Specialist co-insurance</u>	20%
■ <u>Hospital (facility) co-insurance</u>	20%
■ <u>Other co-insurance</u>	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	\$1,925
Co-payments	\$0
Co-insurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,925</b>