



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](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary on [myBlue Member](#) or call 601-664-4590 or 1-800-942-0278 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">Network</a> : \$900 per Individual / \$1,800 per Family. <a href="#">Non-Network</a> : \$1,800 per Individual / \$3,600 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and certain medical services with <a href="#">copayments</a> 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="#">copayment</a> or <a href="#">coinsurance</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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$100 per Individual for <a href="#">prescription drug coverage</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">Network Providers</a> : \$6,850 per Individual / \$13,700 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Balance-billed</a> charges, <a href="#">non-network deductibles</a> , <a href="#">non-network coinsurance</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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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 <a href="#">plan's 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 <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) 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)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	\$25 / office visit; <a href="#">Deductible</a> does not apply.	50% <a href="#">Coinsurance</a>	Other Covered Services rendered in the <a href="#">Network Provider's</a> office will be subject to the <a href="#">Network Coinsurance</a> amount.
	<a href="#">Specialist</a> visit	\$40 / office visit; <a href="#">Deductible</a> does not apply.	50% <a href="#">Coinsurance</a>	Other Covered Services rendered in the <a href="#">Network Provider's</a> office will be subject to the <a href="#">Network Coinsurance</a> amount. Routine vision and podiatry are not covered. See <a href="#">Rehabilitation 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> <a href="#">Network Provider</a> in that <a href="#">Provider's</a> 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)	20% <a href="#">Coinsurance</a>	Not covered	Benefits listed are for Independent Labs and Diagnostic Services Facilities. 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)	20% <a href="#">Coinsurance</a>	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)	Out-of-Network Provider (You will pay the most)		
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsms.com">www.bcbsms.com</a>.</p>	Category One Drugs	\$10 /prescription	Not covered	<p>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.</p> <p>Prescription <a href="#">Deductible</a> is waived for Category One drugs.</p>	
	Category Two Drugs	\$25 /prescription	Not covered		
	Category Three Drugs	\$50 /prescription	Not covered		
	Category Four Drugs	\$100 / prescription	Not covered		
	Category One Maintenance Drugs	\$25 / Generic prescription	\$30 / Brand prescription	Not covered	<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 <a href="#">Deductible</a> is waived for Category One drugs.</p>
	Category Two Maintenance Drugs	\$62.50 / Generic prescription	\$75 / Brand prescription	Not covered	
	Category Three Maintenance Drugs	\$125 / Generic prescription	\$150 / Brand prescription	Not covered	
	Category Four Maintenance Drugs	\$250 / Generic prescription	\$300 / Brand prescription	Not covered	
	Disease Specific Drugs	10% of the <a href="#">Allowed Amount</a> up to \$350 <a href="#">Copayment</a> with a minimum of \$100 <a href="#">Copayment</a>	Not covered	Not covered	Disease Specific Drugs must be provided by a Network Disease Specific Pharmacy or a Non-Pharmacy Network Provider, be listed in the Disease Specific Drug Formulary and are subject to Prior Authorization.
	Medical Prescription Drugs	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a> or Not Covered	50% <a href="#">Coinsurance</a> or Not Covered	Must be dispensed or administered by a Hospital, Physician or Allied Provider and listed in the Medical Prescription Drug Formulary. <a href="#">Deductible</a> does not apply in Physician's or Allied Provider's office. <a href="#">Non-Network Provider</a> Benefits may vary by place of treatment. No Benefit provided if <a href="#">Non-Network Provider's</a> services are 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)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	Certain Covered Services may be subject to the Specialty Services provisions. *See the Schedule of Benefits-Specialty Services. Prior Authorization may be required if Covered Services can be provided in a lower place of treatment. *See the Ambulatory Surgical Facility Services Article.
	Physician/surgeon fees	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a> for non-emergency services rendered by a <a href="#">Non-Network Provider</a> .
	<a href="#">Emergency medical transportation</a>	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None.
	<a href="#">Urgent care</a>	\$25 / <a href="#">Primary</a> care or \$40 / <a href="#">Specialist</a> office visit; <a href="#">Deductible</a> does not apply.	50% <a href="#">Coinsurance</a>	Other Covered Services rendered in the <a href="#">Network Provider's</a> office will be subject to the <a href="#">Network Coinsurance</a> amount.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from <a href="#">Non-Network Provider</a> . Certain Covered Services may be subject to the Specialty Services provisions. *See the Schedule of Benefits-Specialty Services. Prior Authorization may be required if Covered Services can be provided in a lower place of treatment. *See the Hospital Benefits Article.
	Physician/surgeon fees	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 / office visit; 20% <a href="#">Coinsurance</a> for Outpatient services.	50% <a href="#">Coinsurance</a>	For Outpatient services, other Covered Services rendered in the <a href="#">Network Provider's</a> office will be subject to the <a href="#">Network Coinsurance</a> amount with the <a href="#">Deductible</a> waived. Subject to Care Management, Medical Necessity, and appropriateness of care.
	Inpatient services	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</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)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	\$25 / visit <a href="#">Deductible</a> does not apply.	50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">Copayment</a> , <a href="#">Coinsurance</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	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">Coinsurance</a>	Not covered	Available only through Care Management. *See the Home Health section in Article XIII.
	<a href="#">Rehabilitation services</a>	Inpatient and Outpatient: 20% <a href="#">Coinsurance</a>  Physical Medicine: 20% <a href="#">Coinsurance</a>	Inpatient: Not covered  Outpatient: 50% <a href="#">Coinsurance</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. *See the Inpatient Rehabilitation, Outpatient Cardiac Rehabilitation, Physical Medicine and Speech Therapy sections.
	<a href="#">Habilitation services</a>	Not covered	Not covered	Not covered.
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	Not covered.
	<a href="#">Durable medical equipment</a>	20% <a href="#">Coinsurance</a>	Not covered	Medical Necessity certificate required. *See the Durable Medical Equipment section in Article VIII.
	<a href="#">Hospice services</a>	20% <a href="#">Coinsurance</a>	Not covered	6 month lifetime limitation. *See the Hospice Care section in Article VIII.
If your child needs dental or eye care	Children's eye exam	\$40 / visit	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	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- [Skilled Nursing Care](#)
- Weight Loss Programs

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

- Chiropractic Care
- Dental Care (Limited to children under 19 years of age.)
- [Habilitation Services](#)
- 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 on how 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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### 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](#) \$900
- [Primary Care copayment](#) \$25
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,290
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,260</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$900
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a> *	\$1000
<a href="#">Copayments</a>	\$640
<a href="#">Coinsurance</a>	\$50
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,710</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$900
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$130
<a href="#">Coinsurance</a>	\$310
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,340</b>

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.