Blue Cross & Blue Shield of Mississippi: Blue Health Savings - Small Group **Coverage for:** Individual and/or Family | **Plan Type:** HDHP

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 *my*Blue Member or call 601-664-4590 or 1-800-942-0278 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,900 per Individual / $7,800 per Family Non-Network: $7,800 per Individual / $15,600 per Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Network Providers: $7,500 per Individual / $15,000 per Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Balance-billed charges, non-network deductibles, non-network coinsurance, premiums and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsms.com or call 601-664-4590 or 1-800-942-0278 for a list of Network Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	10% Coinsurance	50% Coinsurance	None.
	Specialist visit	10% Coinsurance	50% Coinsurance	Routine vision is not covered for adults. Routine podiatry is not covered. See Rehabilitation services, below, for additional information.
	Preventive care/screening/ immunization	No charge	Not covered	Covered Services must be rendered by a *Healthy You!* Network Provider in that Provider's setting. Please see www.bcbsms.com/be-healthy/healthy-you-wellness-benefit. You may have to pay for services that aren't preventive. Ask your Provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	Not covered	Benefits listed are for Independent Labs and Diagnostic Services Facilities. Services provided in the Provider's office may be subject to the amounts listed above for Primary or Specialist care.
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsms.com.	Category One Drugs	10% Coinsurance	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	10% Coinsurance	Not covered	
	Category Three Drugs	10% Coinsurance	Not covered	
	Category Four Drugs	10% Coinsurance	Not covered	
	Category One Maintenance Drugs	10% Coinsurance	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 the Prescription Drug Benefits section in Article VIII.
	Category Two Maintenance Drugs	10% Coinsurance	Not covered	
	Category Three Maintenance Drugs	10% Coinsurance	Not covered	
	Category Four Maintenance Drugs	10% Coinsurance	Not covered	

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)	
	Disease Specific Drugs	10% Coinsurance	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	10% Coinsurance	50% Coinsurance or Not Covered	Must be dispensed or administered by a Hospital, Physician or Allied Provider and listed in the Medical Prescription Drug Formulary. Deductible does not apply in Physician's or Allied Provider's office. Non-Network Provider Benefits may vary by place of treatment. No Benefit provided if Non-Network Provider's services are not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	50% Coinsurance	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	10% Coinsurance	50% Coinsurance	None.
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	50% Coinsurance for non-emergency services rendered by a Non-Network Provider.
	Emergency medical transportation	10% Coinsurance	50% Coinsurance	None.
	Urgent care	10% Coinsurance	50% Coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	50% Coinsurance	Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from Non-Network Provider. 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	10% Coinsurance	50% Coinsurance	None.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	10% Coinsurance	50% Coinsurance	Subject to Care Management, Medical Necessity, and appropriateness of care.
	Inpatient services	10% Coinsurance	50% Coinsurance	
If you are pregnant	Office visits	10% Coinsurance	50% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a Copayment, Coinsurance, or Deductible 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	10% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	10% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	Not covered	Available only through Care Management. *See the Home Health section in Article XIII.
	Rehabilitation services	Inpatient and Outpatient: 10% Coinsurance Physical Medicine: 10% Coinsurance	Inpatient: Not covered Outpatient: 50% Coinsurance Physical Medicine: Not covered	Inpatient Rehabilitation limited to 30 days per year by a 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 a Network Provider. Speech Therapy limited to 20 outpatient visits per year. *See the Inpatient Rehabilitation, Outpatient Cardiac Rehabilitation, Physical Medicine and Speech Therapy sections.
	Habilitation services	10% Coinsurance	Not covered	Limited to 20 Physical Therapy and Occupational Therapy visits, combined, and 20 Speech Therapy visits.
	Skilled nursing care	Not covered	Not covered	Not covered.
	Durable medical equipment	10% Coinsurance	Not covered	Medical Necessity certificate required. *See the Durable Medical Equipment section in Article VIII.
	Hospice services	10% Coinsurance	Not covered	6 month lifetime limitation. *See the Hospice Care section in Article VIII.

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 your child needs dental or eye care	Children's eye exam	10% Coinsurance	Not covered	Limited to one exam per year. Limited to children under 19 years of age.
	Children's glasses	The difference between the allowed amount 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.
	Children's dental check-up	10% Coinsurance	10% Coinsurance	Limited to one check-up every six months. Limited to children under 19 years of age.

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 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 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.

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.

* For more information about limitations and exceptions, see the plan or policy document on the Member page at www.bcbsms.com.

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, kwiijigo 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	$3,900
Primary Care coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,900
Copayments	$0
Coinsurance	$850
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,810**

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

The plan's overall deductible	$3,900
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

The plan's overall deductible	$3,900
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.