



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 [www.healthcare.gov/sbc-glossary](http://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> : \$5,450 per Individual / \$10,900 per Family. <a href="#">Non-Network</a> : \$10,900 per Individual / \$21,800 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> and 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> .
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> : \$9,200 per Individual / \$18,400 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> ?	<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> .
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 <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.
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 [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	40% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None.
	<a href="#">Specialist</a> visit	40% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	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)	40% <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)	40% <a href="#">Coinsurance</a>	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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.bcbsms.com">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 the Prescription Drug Benefits section in Article VIII.  <u>Deductible</u> is waived for Category One drugs.
	Category Two Drugs	40% <a href="#">Coinsurance</a>	Not covered	
	Category Three Drugs	40% <a href="#">Coinsurance</a>	Not covered	
	Category Four Drugs	40% <a href="#">Coinsurance</a>	Not covered	
	Category One Maintenance Drugs	40% <a href="#">Coinsurance</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 the Prescription Drug Benefits section in Article VIII.  <u>Deductible</u> is waived for Category One drugs.
	Category Two Maintenance Drugs	40% <a href="#">Coinsurance</a>	Not covered	
	Category Three Maintenance Drugs	40% <a href="#">Coinsurance</a>	Not covered	
	Category Four Maintenance Drugs	40% <a href="#">Coinsurance</a>	Not covered	
	Disease Specific Drugs	40% <a href="#">Coinsurance</a>	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	40% <a href="#">Coinsurance</a>	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="#">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.

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)	40% <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	40% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">Coinsurance</a>	40% <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>	40% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None.
	<a href="#">Urgent care</a>	40% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <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	40% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	Subject to Care Management, Medical Necessity, and appropriateness of care.
	Inpatient services	40% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	
If you are pregnant	Office visits	40% <a href="#">Coinsurance</a>	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	40% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	
	Childbirth/delivery facility services	40% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	40% <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: 40% <a href="#">Coinsurance</a>  Physical Medicine: 40% <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>	40% <a href="#">Coinsurance</a>	Not covered	Medical Necessity certificate required. *See the Durable Medical Equipment section in Article VIII.
	<a href="#">Hospice services</a>	40% <a href="#">Coinsurance</a>	Not covered	6 month lifetime limitation. *See the Hospice Care section in Article VIII.
<b>If your child needs dental or eye care</b>	Children's eye exam	40% <a href="#">Coinsurance</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="#">Coinsurance</a>	40% <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.

## 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                                     | • <a href="#">Skilled Nursing Care</a> |
| • 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  | • <a href="#">Habilitation Services</a>                         |
| • 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 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): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 601-664-4590 or 1-800-942-0278.

Pennsylvania Dutch (Deitsh): Fer Hilf griegie in Deitsch, ruf 601-664-4590 or 1-800-942-0278 uff.

Samoa (Gagana Samoa): Mo se fesoasoani i le Gagan Samoa, vala' au mai i le numera telefoni 601-664-4590 or 1-800-942-0278.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 601-664-4590 or 1-800-942-0278.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 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.*

\* 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).

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,450
■ <a href="#">Primary Care coinsurance</a>	40%
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	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>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,450
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,760
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,280</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,450
■ <a href="#">Specialist coinsurance</a>	40%
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,930
<a href="#">Copayments</a>	\$130
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,080</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,450
■ <a href="#">Specialist coinsurance</a>	40%
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	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>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,790
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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