



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsms.com](http://www.bcbsms.com) or by calling 1-800-222-8046.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	For Network Providers: <b>\$3,000</b> for Individuals, <b>\$6,000</b> for Individuals plus 1, and <b>\$9,000</b> for Individuals plus 2 or more. For Non-Network Providers: <b>\$3,300</b> for Individuals, <b>\$6,600</b> for Individuals plus 1, and <b>\$9,900</b> for Individuals plus 2 or more. Doesn't apply to preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1 <sup>st</sup> ). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	This plan has no out-of-pocket limit.	Not applicable because there's no <u>out-of-pocket limit</u> on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.bcbsms.com">www.bcbsms.com</a> or call 1-800-222-8046 for a list of Network Providers	If you use an in-network doctor or other healthcare <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered healthcare, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **Providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a healthcare <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge	No charge	-----none-----
	Specialist visit	No charge	No charge	-----none-----
	Other practitioner office visit	No charge	No charge	Chiropractic Services limited to \$500 per year. Routine vision and podiatry is not covered.
	Preventive care/screening/immunization	No charge	Not covered	Services must be rendered by a <i>Healthy You!</i> Network Provider in that Provider's clinical setting and according to the Preventive Health Services Age and Gender Guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	No charge	-----none-----

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.bcbsms.com">www.bcbsms.com</a>.</p>	Category One Drugs	No charge	Not covered	Limited to a 30 day retail supply	
	Category Two Drugs	No charge	Not covered		
	Category Three Drugs	No charge	Not covered		
	Category Four Drugs	No charge	Not covered		
		Category One Mail-Order Maintenance Drugs	No charge	Not covered	Limited to a 90 day mail-order supply
		Category Two Mail-Order Maintenance Drugs	No charge	Not covered	
		Category Three Mail-Order Maintenance Drugs	No charge	Not covered	
		Category Four Mail-Order Maintenance Drugs	No charge	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	-----none-----	
	Physician/surgeon fees	No charge	No charge	-----none-----	
<p><b>If you need immediate medical attention</b></p>	Emergency room services	No charge	No charge	-----none-----	
	Emergency medical transportation	No charge	No charge	-----none-----	
	Urgent care	No charge	No charge	-----none-----	
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	No charge	No charge	Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from non-network provider.	
	Physician/surgeon fee	No charge	No charge	-----none-----	

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# MS CONFERENCE OF THE UNITED METHODIST CHURCH

Coverage Period: 1/1/2016 - 12/31/2016

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: HDHP**

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	No charge	Subject to Care Management.
	Mental/Behavioral health inpatient services	No charge	No charge	Subject to Care Management.
	Substance use disorder outpatient services	No charge	No charge	Subject to Care Management.
	Substance use disorder inpatient services	No charge	No charge	Subject to Care Management.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Maternity coverage is not available for dependent children.
	Delivery and all inpatient services	No charge	No charge	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to 100 visits per year. Available only through Care Management
	Rehabilitation services	No charge	Inpatient: Not covered; Outpatient: No charge	Inpatient Rehabilitation limited to 30 days per year by Network Provider. Outpatient Cardiac Rehab limited to 36 visits per year and must be rendered by Network Provider. Speech Therapy not available for learning or developmental disabilities.
	Habilitation services	Not covered	Not covered	Habilitation services are not available.
	Skilled nursing care	Not covered	Not covered	-----none-----
	Durable medical equipment	No charge	No charge	-----none-----
	Hospice service	No charge	No charge	6 month lifetime limitation.

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Routine dental and eye care are not available.
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

**Excluded Services & Other Covered Services:**

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine Eye Care</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)
<ul style="list-style-type: none"> <li>• Chiropractic Care</li> </ul>

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## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 601-354-0515. You may also contact your state insurance department, 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 the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan at 601-354-0515 or Blue Cross & Blue Shield of Mississippi at 1-800-222-8046.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-222-8046.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-222-8046.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-222-8046.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'1-800-222-8046.

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

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**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,390
- Patient pays \$3,150

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$3,000
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,150</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,180
- Patient pays \$3,220

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$3,000
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$220
<b>Total</b>	<b>\$3,220</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-Network Providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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