

Millsaps College Employee Health Protection Plan

Coverage for: Individual and/or Family | Plan Type: HD-PPO



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, or to get a copy of the complete terms of coverage, contact the [Plan](#) at 601-974-1443, visit us at www.bcbsms.com or call 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:
What is the overall deductible ?	<p>Network Providers: \$3,000 per Individual \$9,000 per Family.</p> <p>Non-Network Providers: \$6,000 per Individual \$18,000 per Family.</p>	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 , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care is 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 ?	<p>Network Providers: \$6,900 per Individual \$13,800 per Family.</p> <p>Non-Network Providers: \$13,800 per Individual \$27,600 per Family.</p>	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, 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)	Non-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	20% Coinsurance after Deductible	40% Coinsurance after Deductible	None.
	Specialist visit	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Chiropractic Care limited to 26 visits per year. Routine vision and podiatry are not covered. See Rehabilitation services , below, for additional information.
	Preventive care/screening/immunization	No charge Deductible waived	40% Coinsurance after Deductible	Certain Preventive Services must be rendered by a Network Provider in that Provider's setting to be covered. 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. * See the Schedule of Benefits and the Outpatient Preventive/Wellness Services section.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	None.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	None.
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	20% Coinsurance after Deductible	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. *See the Prescription Drug Benefits section in Article VIII.
	Category Two Drugs	20% Coinsurance after Deductible	Not covered	
	Category Three Drugs	20% Coinsurance after Deductible	Not covered	
	Category Four Drugs	20% Coinsurance after Deductible	Not covered	

* For more information about limitations and exceptions, see the [Plan](#) or policy document on the Member page at 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>Coinsurance</u> after <u>Deductible</u>	Not covered	Available as a 90-day Maintenance supply. Certain Prescription drugs may be subject to Prior Authorization, quantity limits, day limits and/or duration of use restrictions. *See the Prescription Drug Benefits section in Article VIII.
	Category Two Maintenance Drugs	20% <u>Coinsurance</u> after <u>Deductible</u>	Not covered	
	Category Three Maintenance Drugs	20% <u>Coinsurance</u> after <u>Deductible</u>	Not covered	
	Category Four Maintenance Drugs	20% <u>Coinsurance</u> after <u>Deductible</u>	Not covered	
	Category One Mail-Order Drugs	20% <u>Coinsurance</u> after <u>Deductible</u>	Not covered	Limited to a 90-day Mail Order supply. Certain Prescription drugs may be subject to Prior Authorization, quantity limits, day limits and/or duration of use restrictions. *See the Prescription Drug Benefits section in Article VIII.
	Category Two Mail-Order Drugs	20% <u>Coinsurance</u> after <u>Deductible</u>	Not covered	
	Category Three Mail-Order Drugs	20% <u>Coinsurance</u> after <u>Deductible</u>	Not covered	
	Category Four Mail-Order Drugs	20% <u>Coinsurance</u> after <u>Deductible</u>	Not covered	
	Disease Specific Drugs	20% <u>Coinsurance</u> after <u>Deductible</u>	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% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u> 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.

* For more information about limitations and exceptions, see the [Plan](#) or policy document on the Member page at 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	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% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	None.
If you need immediate medical attention	Emergency room care	20% <u>Coinsurance</u> after <u>Deductible</u>	20% <u>Coinsurance</u> after <u>Deductible</u>	Your cost if you use a <u>Non-Network Provider</u> for non-emergency services will be 40% <u>Coinsurance</u> after <u>Deductible</u> .
	Emergency medical transportation	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	None.
	Urgent care	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</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 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% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	Other Covered Services rendered in the <u>Network Provider's</u> office will be subject to the <u>Network Coinsurance</u> amount with the <u>Deductible</u> waived. Subject to Care Management, Medical Necessity, and appropriateness of care.
	Inpatient services	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	Subject to Care Management, Medical Necessity, and appropriateness of care.

* For more information about limitations and exceptions, see the [Plan](#) or policy document on the Member page at 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 are pregnant	Office visits	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>Coinsurance</u> or a <u>Deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	
	Childbirth/delivery facility services	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	
If you need help recovering or have other special health needs	Home health care	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	Limited to 100 visits per year. *See the Home Health section in Article VIII.
	Rehabilitation services	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	Inpatient Rehabilitation limited to 30 days per year by <u>Network Provider</u> . Outpatient Cardiac Rehabilitation limited to 36 visits per year and must be rendered by <u>Network Provider</u> . Chiropractic Care limited to 26 visits per year. *See the Inpatient Rehabilitation and Outpatient Cardiac Rehabilitation sections.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	20% <u>Coinsurance</u> after <u>Deductible</u>	20% <u>Coinsurance</u> after <u>Deductible</u>	Limited to 120 days per year.
	Durable medical equipment	20% <u>Coinsurance</u> after <u>Deductible</u>	40% <u>Coinsurance</u> after <u>Deductible</u>	Medical Necessity certificate required. *See the Durable Medical Equipment section in Article VIII.
	Hospice services	No charge after Deductible	No charge after Deductible	Subject to Case Management. *See the Hospice section in Article VIII.
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	

* For more information about limitations and exceptions, see the [Plan](#) or policy document on the Member page at 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
- Habilitation Services
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine Eye Care
- Routine Foot 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 (limited to 26 visits per year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For information on your rights to continue coverage, contact the Plan at 601-974-1443. 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 at 601-974-1443, Blue Cross & Blue Shield of Mississippi at 601-664-4590 or 1-800-942-0278.

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** \$3,000
- **Primary Care coinsurance** 20%
- **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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$1,870
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,930

Managing Joe's Type 2 Diabetes

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

- **The Plan's overall deductible** \$3,000
- **Specialist coinsurance** 20%
- **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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,300
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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** \$3,000
- **Specialist coinsurance** 20%
- **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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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.