

 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, visit <http://KnowYourBenefits.dfa.ms.gov> or call 1-800-709-7881. 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 also view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov).

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> and <u>Out-of-network</u> : \$1,800/individual; \$3,000/family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care network</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	Yes. Preventive <u>prescription drugs</u> : \$75/individual. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>Network providers</u> : \$6,500/individual; \$13,000/family. <u>Out-of-network providers</u> : no <u>out-of-pocket limit</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain prior approval.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. Go here for a list of <u>network providers</u> or call 1-800-294-6307.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness <u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Online provider visit: \$10 (Subject to <u>deductible</u> )
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive, then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (X-ray, blood work). Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you need drugs to treat your illness or condition, or information about <u>prescription drug coverage</u>. Additional information is available at <a href="http://www.MyPrime.com">www.MyPrime.com</a></b>	Preferred Generic drugs Non-Preferred Generic drugs	Retail: \$12 <u>copay</u> Retail: \$30 <u>copay</u>	You pay 100% then request reimbursement of the <u>in-network</u> amount, less the applicable <u>deductible</u> or <u>copay</u> .	\$75 individual preventive <u>prescription drug deductible</u> (for certain preventive medications) if the Base Coverage <u>deductible</u> has not been met. Mail Order (2X Copay) quantity 60-90 day supply. No charge for FDA-approved generic contraceptives or brand name contraceptives if a generic is medically inappropriate or unavailable. If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug plus the generic <u>copayment</u> . Certain prescriptions require prior approval.
	Preferred brand drugs	Retail: \$45 <u>copay</u> Mail order: \$90 <u>copay</u>		
	Non-preferred brand drugs	Retail: \$100 <u>copay</u> Mail order: \$200 <u>copay</u>		
	<u>Specialty drugs</u>	Retail: \$100 <u>copay</u>	Not covered.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center) <u>Provider/surgeon</u> fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$50 <u>copay</u> /1 <sup>st</sup> visit; \$200 <u>copay</u> /each additional visit plus 20% <u>coinsurance</u> .	\$50 <u>copay</u> /1 <sup>st</sup> visit; \$200 <u>copay</u> /each additional visit plus 20% <u>coinsurance</u> .	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior approval required to avoid penalty. Penalty for no prior approval: \$500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): \$250.
	Provider/surgeon fees			
<b>If you need mental health, behavioral health or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior approval required to avoid penalty. Penalty for no prior approval: \$500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): \$250.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive <u>screenings</u> ) is not covered for dependent children.
	Childbirth/delivery professional services Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification required.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maintenance or exercise therapy is excluded.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification Required. Benefits available for up to six months.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service, even in <u>network</u> .
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in <u>network</u> .
	Children's dental checkup	Not covered.	Not covered.	You must pay 100% of this service, even in <u>network</u> .

## 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
- Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease)
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Weight loss programs (except as required by ACA)

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

- Bariatric surgery (prior approval required)
- Chiropractic services (limited to 30 visits/individual/year)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (prior approval required)

**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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 <https://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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, call the claims administrator at 1-800-709-7881. Additionally, a consumer assistance program can help you file your appeal. Contact [Health Help Mississippi](#) at 1-877-314-3843 or [healthhelpms@mhap.org](mailto:healthhelpms@mhap.org).

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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](#).

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————



**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 prenatal care and a hospital delivery)

■ <b>The plan's overall deductible</b>	<b>\$1,800</b>
■ <b>Specialist coinsurance</b>	<b>20%</b>
■ <b>Hospital (facility) coinsurance</b>	<b>20%</b>
■ <b>Other coinsurance</b>	<b>20%</b>

**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>\$12,800</b>
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**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,800
<u>Copayments</u>	\$60
<u>Coinsurance</u>	\$2,132
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,992</b>

### Managing Joe's type 2 Diabetes

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

■ <b>The plan's overall deductible</b>	<b>\$1,800</b>
■ <b>Specialist coinsurance</b>	<b>20%</b>
■ <b>Hospital (facility) coinsurance</b>	<b>20%</b>
■ <b>Other coinsurance</b>	<b>20%</b>

**This EXAMPLE event includes services like:**

Primary care provider office visits (including disease education)  
Diagnostic test (blood work)  
Prescription drugs  
Durable medical equipment (glucose meter)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,250
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,050</b>

### Mia's Simple Fracture

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

■ <b>The plan's overall deductible</b>	<b>\$1,800</b>
■ <b>Specialist coinsurance</b>	<b>20%</b>
■ <b>Hospital (facility) coinsurance</b>	<b>20%</b>
■ <b>Other coinsurance</b>	<b>20%</b>

**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>\$1,900</b>
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**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,800
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,880</b>

