



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 <https://www.dfa.ms.gov/insurance> 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 <a href="#">deductible</a> ?	<a href="#">Network</a> and <a href="#">Out-of-network</a> : \$1,800/individual; \$3,400/family.	Generally, you must pay all of the costs from <a href="#">providers</a> 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 policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">In-network preventive care</a> is 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 <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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?	Yes. Preventive <a href="#">prescription drugs</a> : \$75/individual. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network providers</a> : \$6,500/individual; \$13,000/family. <a href="#">Out-of-network providers</a> : no <a href="#">out-of-pocket limit</a> .	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="#">Premiums</a> , <a href="#">balance-billing</a> , charges this health care <a href="#">plan</a> doesn't cover and penalties for failure to obtain prior approval.	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. Go here for a list of <a href="#">network providers</a> or call 1-800-294-6307.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> 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 and 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	Primary care visit to treat an injury or illness <a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Telehealth provider visit: \$10 <a href="#">Copayment</a> (Subject to <a href="#">deductible</a> )
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive, 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). Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition, or information about <a href="#">prescription drug coverage</a> . Additional information is available at <a href="http://www.caremark.com">www.caremark.com</a>	Preferred Generic drugs	Retail: \$12 <a href="#">copay</a> Mail order: \$24 <a href="#">copay</a>	You pay 100% then request reimbursement of the <a href="#">in-network</a> amount, less the applicable <a href="#">deductible</a> or <a href="#">copay</a> .	\$75 individual preventive <a href="#">prescription drug deductible</a> (for certain preventive medications) if the Base Coverage <a href="#">deductible</a> 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 brand <a href="#">copayment</a> . Certain prescriptions require prior approval.
	Non-Preferred Generic drugs	Retail: \$30 <a href="#">copay</a> Mail order: \$60 <a href="#">copay</a>		
	Preferred brand drugs	Retail: \$45 <a href="#">copay</a> Mail order: \$90 <a href="#">copay</a>		
	Non-preferred brand drugs	Retail: \$100 <a href="#">copay</a> Mail order: \$200 <a href="#">copay</a>		
	<a href="#">Specialty drugs</a>	Retail: \$100 <a href="#">copay</a>	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) <a href="#">Provider/surgeon</a> fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> /1 <sup>st</sup> visit; \$200 <a href="#">copay</a> /each additional visit plus 20% <a href="#">coinsurance</a> .	\$50 <a href="#">copay</a> /1 <sup>st</sup> visit; \$200 <a href="#">copay</a> /each additional visit plus 20% <a href="#">coinsurance</a> .	<a href="#">Copayment</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

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)	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room) Provider/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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.
<b>If you need mental health, behavioral health or substance abuse services</b>	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you are pregnant</b>	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive <a href="#">screenings</a> ) is not covered for dependent children.
	Childbirth/delivery professional services Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Certification required.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Certification required.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maintenance or exercise therapy is excluded.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Certification required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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 <a href="#">network</a> .
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in <a href="#">network</a> .
	Children's dental checkup	Not covered.	Not covered.	You must pay 100% of this service, even in <a href="#">network</a> .

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease)</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Children)</li><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Routine eye care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Children)</li><li>• Routine foot care</li><li>• Weight loss programs (except as required by ACA)</li></ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Bariatric surgery (prior approval required)</li><li>• Chiropractic services (limited to 30 visits/individual/year)</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (prior approval required)</li></ul>

**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)

- The [plan's](#) overall [deductible](#) \$1,800
- [Specialist 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	\$12,800
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,000</b>

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

- The [plan's](#) overall [deductible](#) \$1,800
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Primary care provider](#) office visits (*including chronic condition education*)
- [Diagnostic test](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,800
<a href="#">Copayments</a>	\$144
<a href="#">Coinsurance</a>	\$1091.20
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$3,035.20</b>

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

- The [plan's](#) overall [deductible](#) \$1,800
- [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	\$1,900
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,800
<a href="#">Copayments</a>	\$50
<a href="#">Coinsurance</a>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,860</b>



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Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network</a> : \$1,800/individual; \$3,600/family. <a href="#">Out-of-network</a> : \$2,300/individual; \$4,600/family.	Generally, you must pay all of the costs from <a href="#">providers</a> 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 policy, payments made on individual <a href="#">deductible</a> will combine towards the family <a href="#">deductible</a> until the \$3,600 is met.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">In-network preventive care</a> and primary care <a href="#">network</a> provider office visits 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 <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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?	Yes. <a href="#">Prescription drugs</a> : \$75/individual. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network providers</a> : \$6,500/individual; \$13,000/family. <a href="#">Out-of-network providers</a> : no <a href="#">out-of-pocket limit</a> .	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="#">Premiums</a> , <a href="#">balance-billing</a> , <a href="#">charges</a> this health care <a href="#">plan</a> doesn't cover and penalties for failure to obtain prior approval.	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. Go here for a list of <a href="#">network providers</a> or call 1-800-294-6307.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> 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 and Other Important Information
		In-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	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a>	Telehealth provider visit: \$10 <a href="#">copayment</a>
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive, 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)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition, or information about <a href="#">prescription drug coverage</a> . Additional information is available at <a href="http://www.caremark.com">www.caremark.com</a>	Preferred Generic drugs	Retail: \$12 <a href="#">copay</a> Mail order: \$24 <a href="#">copay</a>	You pay 100% then request reimbursement of the <a href="#">in-network</a> amount, less the applicable <a href="#">deductible</a> or <a href="#">copay</a> .	\$75 individual <a href="#">prescription drug deductible</a> 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 brand <a href="#">copayment</a> . Certain prescriptions require prior approval **PrudentRx coupon program will allow enrolled participants to pay \$0.
	Non-Preferred Generic drugs	Retail: \$30 <a href="#">copay</a> Mail order: \$60 <a href="#">copay</a>		
	Preferred brand drugs	Retail: \$45 <a href="#">copay</a> Mail order: \$90 <a href="#">copay</a>		
	Non-preferred brand drugs	Retail: \$100 <a href="#">copay</a> Mail order: \$200 <a href="#">copay</a>		
	<a href="#">Specialty drugs</a> **	30% <a href="#">coinsurance</a>	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Provider/surgeon</a> fees			
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> /1 <sup>st</sup> visit; \$200 <a href="#">copay</a> /each additional visit plus 20% <a href="#">coinsurance</a>	\$50 <a href="#">copay</a> /1 <sup>st</sup> visit; \$200 <a href="#">copay</a> /each additional visit plus 20% <a href="#">coinsurance</a>	<a href="#">Copayment</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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			
If you need mental health, behavioral health or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive <a href="#">screenings</a> ) is not covered for dependent children.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Certification required.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Certification required.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maintenance or exercise therapy is excluded.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Certification required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Certification Required. Benefits available for up to six months.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service, even <a href="#">in-network</a> .
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even <a href="#">in-network</a> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental checkup	Not covered.	Not covered.	You must pay 100% of this service, even <a href="#">in-network</a> .

**Excluded Services and 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](#).)**

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease)</li> <li>• Dental care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Children)</li> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Children)</li> <li>• Routine foot care</li> <li>• Weight loss programs (except as required by ACA)</li> </ul> |
|--|---|--|

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

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Bariatric surgery (prior approval required)</li> <li>• Chiropractic services (limited to 30 visits/individual/year)</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing (prior approval required)</li> </ul> |
|---|--|--|

**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)

- The [plan's](#) overall [deductible](#) \$1,800
- [Specialist 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a> (Medical and Rx)	\$1,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,180
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,980</b>

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

- The [plan's](#) overall [deductible](#) \$1,800
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:  
[Primary care provider](#) office visits (*including chronic condition education*)  
[Diagnostic test](#) (*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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a> (Medical and Rx)	\$75
<a href="#">Copayments</a>	\$194
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$469</b>

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

- The [plan's](#) overall [deductible](#) \$1,800
- [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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,800
<a href="#">Copayments</a>	\$50
<a href="#">Coinsurance</a>	\$190
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,040</b>