



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 at <https://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> : \$6,000<br><a href="#">Non-Network</a> : \$12,000                                                                                                                  | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 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?              | Yes. \$250 for <a href="#">prescription drug coverage</a> . 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> ? | For <a href="#">Network Providers</a> : \$9,200                                                                                                                                              | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 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<br>(You will pay the least)                   | Out-of-Network Provider<br>(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 | \$30 / office visit <a href="#">Deductible</a> does not apply. | 50% <a href="#">Coinsurance</a>                    | Other Covered Services rendered in the <a href="#">Network Provider's</a> office will be subject to the <a href="#">Network Coinsurance</a> amount.                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                        | <a href="#">Specialist</a> visit                                 | \$40 / office visit <a href="#">Deductible</a> does not apply. | 50% <a href="#">Coinsurance</a>                    | Other Covered Services rendered in the <a href="#">Network Provider's</a> office will be subject to the <a href="#">Network Coinsurance</a> amount. Routine vision and podiatry are not covered. See <a href="#">Rehabilitation services</a> and <a href="#">Habilitation 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)              | 20% <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)                                     | 20% <a href="#">Coinsurance</a>                                | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

| Common Medical Event                                                                                                                                                                                  | Services You May Need            | What You Will Pay                                                                                                                                    |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                       |                                  | Network Provider<br>(You will pay the least)                                                                                                         | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsms.com">www.bcbsms.com</a> . | Category One Drugs               | \$15 / 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.<br><br>Prescription <a href="#">Deductible</a> is waived for Category One drugs. |
|                                                                                                                                                                                                       | Category Two Drugs               | \$35 / prescription                                                                                                                                  | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                       | Category Three Drugs             | \$75 / prescription                                                                                                                                  | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                       | Category Four Drugs              | \$100/ prescription                                                                                                                                  | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                       | Category One Maintenance Drugs   | \$37.50 / Generic prescription                                                                                                                       | \$45 / Brand prescription                          | 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.<br><br>Prescription <a href="#">Deductible</a> is waived for Category One drugs.         |
|                                                                                                                                                                                                       | Category Two Maintenance Drugs   | \$87.50 / Generic prescription                                                                                                                       | \$105 / Brand prescription                         |                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                       | Category Three Maintenance Drugs | \$187.50 / Generic prescription                                                                                                                      | \$225 / Brand prescription                         |                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                       | Category Four Maintenance Drugs  | \$250 / Generic prescription                                                                                                                         | \$300 / Brand prescription                         |                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                       | Disease Specific Drugs           | Per 30-day supply, 10% of the <a href="#">Allowed Amount</a> up to \$350 <a href="#">Copayment</a> with a minimum of \$100 <a href="#">Copayment</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       | 20% <a href="#">Coinsurance</a>                                                                                                                      | Not covered                                        | Must be dispensed or administered by a Hospital, Physician or Allied Provider and listed in the Medical Prescription Drug Formulary. Medical <a href="#">Deductible</a> applies. Non-Network Provider Benefits may vary by place of treatment. No Benefit provided if Non-Network Provider's services are not covered.                                      |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                 |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                                                      | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                               |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <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                           | 20% <a href="#">Coinsurance</a>                                                                                                   | 50% <a href="#">Coinsurance</a>                    | None.                                                                                                                                                                                                                                                                                                                                                                                                                         |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 20% <a href="#">Coinsurance</a>                                                                                                   | 20% <a href="#">Coinsurance</a>                    | A \$350 <a href="#">Copayment</a> will be applied for non-emergency services. 50% <a href="#">Coinsurance</a> for non-emergency services rendered by a <a href="#">Non-Network Provider</a> . <a href="#">Deductible</a> applies.                                                                                                                                                                                             |
|                                                                           | <a href="#">Emergency medical transportation</a> | 20% <a href="#">Coinsurance</a>                                                                                                   | 50% <a href="#">Coinsurance</a>                    | None.                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                           | <a href="#">Urgent care</a>                      | \$30 / <a href="#">Primary</a> care or \$40 / <a href="#">Specialist</a> office visit; <a href="#">Deductible</a> does not apply. | 50% <a href="#">Coinsurance</a>                    | Other Covered Services rendered in the <a href="#">Network Provider's</a> office will be subject to the <a href="#">Network Coinsurance</a> amount.                                                                                                                                                                                                                                                                           |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <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                           | 20% <a href="#">Coinsurance</a>                                                                                                   | 50% <a href="#">Coinsurance</a>                    | None.                                                                                                                                                                                                                                                                                                                                                                                                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$30 / office visit; 20% <a href="#">Coinsurance</a> for Outpatient services.                                                     | 50% <a href="#">Coinsurance</a>                    | For Outpatient services, other Covered Services rendered in the <a href="#">Network Provider's</a> office will be subject to the <a href="#">Network Coinsurance</a> amount with the <a href="#">Deductible</a> waived. Subject to Care Management, Medical Necessity, and appropriateness of care.                                                                                                                           |
|                                                                           | Inpatient services                               | 20% <a href="#">Coinsurance</a>                                                                                                   | 50% <a href="#">Coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                                                               |

\* 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).

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                                                                         |                                                                                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least)                                                                              | Out-of-Network Provider<br>(You will pay the most)                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you are pregnant                                            | Office visits                             | \$30 / visit<br><a href="#">Deductible</a> does not apply.                                                                | 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 | 20% <a href="#">Coinsurance</a>                                                                                           | 50% <a href="#">Coinsurance</a>                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                | Childbirth/delivery facility services     | 20% <a href="#">Coinsurance</a>                                                                                           | 50% <a href="#">Coinsurance</a>                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 20% <a href="#">Coinsurance</a>                                                                                           | Not covered                                                                                                        | Available only through Care Management.<br>*See the Home Health section in Article XIII.                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                | <a href="#">Rehabilitation services</a>   | Inpatient and Outpatient:<br>20% <a href="#">Coinsurance</a><br><br>Physical Medicine:<br>20% <a href="#">Coinsurance</a> | Inpatient: Not covered<br><br>Outpatient:<br>50% <a href="#">Coinsurance</a><br><br>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>     | 20% <a href="#">Coinsurance</a>                                                                                           | Not covered                                                                                                        | Limited to 20 Physical Therapy and Occupational Therapy visits, combined, and 20 Speech Therapy visits.                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                | <a href="#">Skilled nursing care</a>      | Not covered                                                                                                               | Not covered                                                                                                        | Not covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                | <a href="#">Durable medical equipment</a> | 20% <a href="#">Coinsurance</a>                                                                                           | Not covered                                                                                                        | Medical Necessity certificate required. *See the Durable Medical Equipment section in Article VIII.                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                | <a href="#">Hospice services</a>          | 20% <a href="#">Coinsurance</a>                                                                                           | Not covered                                                                                                        | 6 month lifetime limitation. *See the Hospice Care section in Article VIII.                                                                                                                                                                                                                                                                                                                                                                                                                                           |

| Common Medical Event                          | Services You May Need      | What You Will Pay                                                                      |                                                    | Limitations, Exceptions, & Other Important Information                                                                                       |
|-----------------------------------------------|----------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
|                                               |                            | Network Provider<br>(You will pay the least)                                           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                              |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | \$\$40 / office visit                                                                  | 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 | 20% <a href="#">Coinsurance</a>                                                        | 20% <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 <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>Bariatric Surgery</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</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> <li>Private-duty Nursing</li> </ul> | <ul style="list-style-type: none"> <li>Routine Eye Care (Adult)</li> <li>Routine Foot Care</li> <li><a href="#">Skilled Nursing Care</a></li> <li>Weight Loss Programs</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>Chiropractic Care</li> <li>Dental Care (Limited to children under 19 years of age.)</li> </ul>                                                             | <ul style="list-style-type: none"> <li><a href="#">Habilitation Services</a></li> <li>Routine Eye Care (Limited to children under 19 years of age.)</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 Mississippi Insurance Department at 1-800-562-2957 or you can contact the plan at 601-664-4590 or 1-800-942-0278. 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: Blue Cross & Blue Shield of Mississippi at 601-664-4590 or 1-800-942-0278 or the Mississippi Insurance Department at 1-800-562-2957.

#### 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? Not Applicable

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.

Pennsylvania Dutch (Deitsch): Fer Hilf griege 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, â'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.*

## 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> | \$6,000 |
| ■ <a href="#">Primary copayment</a>                             | \$30    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$6,000        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$1,270        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$7,340</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> | \$6,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a> *     | \$1,390        |
| <a href="#">Copayments</a>        | \$760          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,170</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> | \$6,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,290        |
| <a href="#">Copayments</a>        | \$130          |
| <a href="#">Coinsurance</a>       | \$40           |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,460</b> |

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

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