**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 *www.PrimewellHealth.com* or call toll-free (833) 798-1440. 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 *http://www.PrimewellHealth.com* or call toll-free at (833) 798-1440 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes. | This plan covers items and services even if you haven't yet met the deductible amount. |
| **Are there other deductibles for specific services?** | No. | You do not have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Not Applicable. | This plan does not use a provider network. You can receive covered services from any provider. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

* For more information about limitations and exceptions, see the plan or policy document at *www.PrimewellHealth.com*.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & 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 provider's office or clinic** | Primary care visit to treat an injury or illness | No charge | No charge | None |
| | Specialist visit | No charge | No charge | None |
| | Preventive care/screening/ immunization | No charge | No charge | None |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | No charge | None |
| | Imaging (CT/PET scans, MRIs) | No charge | No charge | Pre-authorization required. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at *www.PrimewellHealth.com* | Tier 1 – Typically Generic Drugs | No charge | Not covered | None |
| | Tier 2 – Typically Preferred Brand Drugs | No charge | Not covered | None |
| | Tier 3 – Typically Non-Preferred Brand Drugs | No charge | Not covered | None |
| | Tier 4 – Typically Specialty Drugs | No charge | Not covered | None |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | Pre-authorization required. |
| | Physician/surgeon fees | No charge | No charge | Pre-authorization required. |
| **If you need immediate medical attention** | Emergency room care | No charge | No charge | Worldwide emergency coverage. |
| | Emergency medical transportation | No charge | No charge | Emergency criteria required. |
| | Urgent care | No charge | No charge | Pre-authorization required on follow-up visits. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | No charge | Pre-authorization required. |
| | Physician/surgeon fees | No charge | No charge | Pre-authorization required. |

* For more information about limitations and exceptions, see the plan or policy document at *www.PrimewellHealth.com*.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | No charge | None |
| | Inpatient services | No charge | No charge | Pre-authorization required. |
| **If you are pregnant** | Office visits | No charge | No charge | None |
| | Childbirth/delivery professional services | No charge | No charge | Pre-authorization required. |
| | Childbirth/delivery facility services | No charge | No charge | Pre-authorization required. |
| **If you need help recovering or have other special health needs** | Home health care | No charge | No charge | Pre-authorization required. |
| | Rehabilitation services | No charge | No charge | Pre-authorization required. |
| | Habilitation services | No charge | No charge | Pre-authorization required. |
| | Skilled nursing care | No charge | No charge | Pre-authorization required. |
| | Durable medical equipment | No charge | No charge | Pre-authorization required. |
| | Hospice services | No charge | No charge | Pre-authorization required. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge | Limit 1 visit per benefit period. |
| | Children's glasses | No charge | No charge | Limitations may apply. |
| | Children's dental check-up | No charge | No charge | Limit 2 visits per calendar year. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Elective abortions (except when provided to save the life of the mother)
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at *www.PrimewellHealth.com*.

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

- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Routine eye care (Adult)
- Routine foot care

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa Mississippi Insurance Department, Consumer Services Division, P.O. Box 79, Jackson, MS 39205 or call 1-800-562-2957. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit *www.HealthCare.gov* or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Mississippi Insurance Department, Consumer Services Division, P.O. Box 79, Jackson, MS 39205 or call 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 Minimum Value Standards? Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-833-798-1440 (TTY 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-798-1440 (TTY 711).
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-798-1440 (TTY 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-798-1440 (TTY 711).

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



* For more information about limitations and exceptions, see the plan or policy document at *www.PrimewellHealth.com*.

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist (OB/GYN) copayment | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Specialist (OB/GYN) office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| | |
|---|---|
| **Total Example Cost** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$0** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Primary Care Physician copayment | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs Durable medical equipment *(glucose meter)*

| | |
|---|---|
| **Total Example Cost** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$0** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| | |
|---|---|
| **Total Example Cost** | **$2,800** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

The plan would be responsible for the other costs of these EXAMPLE covered services.