
 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 at (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?	For In-Network Providers: \$0. For Out-of-Network Providers : \$5,000 Individual or \$15,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Primary Care and Specialty Care Provider office visits and Wellness and Preventive care are not subject to the deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network providers: \$1,800 Individual/\$3,600 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments and coinsurance on certain services, premiums , balance-billing charges, cost sharing for out-of-network, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.PrimewellHealth.com and click "Find a Provider" or call toll-free at (833) 798-1440 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

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

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	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	\$0 copay . Deductible does not apply.	50% coinsurance	None
	Specialist visit	\$10 copay . Deductible does not apply.	50% coinsurance	None
	Preventive care/screening/ Immunization	No charge. Deductible does not apply.	50% coinsurance . Deductible does not apply.	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance Deductible does not apply.	50% coinsurance	Lab and x-ray services performed in an office setting is covered at no charge.
	Imaging (CT/PET scans, MRIs)	25% coinsurance Deductible does not apply.	50% coinsurance	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 Prescription Drugs	\$0 copay /prescription. Deductible does not apply.	Not covered	This plan has a 4-tier pharmacy benefit. This chart shows what you will typically pay for Generics, Preferred Brand, Non-Preferred Brand, and Specialty Drugs. What you will ultimately pay for drugs will depend on the Tier assigned to that drug. More information about prescription drug coverage is available at www.PrimewellHealth.com/ .
	Tier 2 Prescription Drugs	\$15 copay /prescription. Deductible does not apply.	Not covered	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3 Prescription Drugs	\$50 copay /prescription. Deductible does not apply.	Not covered	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 4 Prescription Drugs	\$150 copay /prescription. Deductible does not apply.	Not covered	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance Deductible does not apply.	50% coinsurance	Pre-authorization required.
	Physician/surgeon fees	25% coinsurance Deductible does not apply.	50% coinsurance	Pre-authorization required.

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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 immediate medical attention	Emergency room care	25% coinsurance Deductible does not apply.	25% coinsurance Deductible does not apply.	Worldwide emergency coverage.
	Emergency medical transportation	25% coinsurance Deductible does not apply.	25% coinsurance Deductible does not apply.	Emergency criteria required.
	Urgent care	\$5 copay /office visit. Deductible does not apply.	50% coinsurance	Pre-authorization required on follow-up visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance Deductible does not apply.	50% coinsurance	Pre-authorization required.
	Physician/surgeon fees	25% coinsurance Deductible does not apply.	50% coinsurance	Pre-authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 copay /visit. Deductible does not apply.	50% coinsurance	None
	Inpatient services	25% coinsurance Deductible does not apply.	50% coinsurance	Pre-authorization required.
If you are pregnant	Office visits	\$0 copay . Deductible does not apply.	50% coinsurance	Copay on initial visit only. Cost sharing does not apply for preventive services . Depending on the type of services, a deductible , copay , or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	25% coinsurance Deductible does not apply.	50% coinsurance	Pre-authorization required.
	Childbirth/delivery facility services	25% coinsurance Deductible does not apply.	50% coinsurance	Pre-authorization required.

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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 help recovering or have other special health needs	Home health care	25% coinsurance Deductible does not apply.	Not covered	Pre-authorization required.
	Rehabilitation services	\$0 copay /visit Deductible does not apply.	50% coinsurance	Pre-authorization required.
	Habilitation services	\$0 copay /visit Deductible does not apply.	50% coinsurance	Pre-authorization required.
	Skilled nursing care	25% coinsurance Deductible does not apply.	50% coinsurance	Pre-authorization required.
	Durable medical equipment	25% coinsurance Deductible does not apply.	50% coinsurance	Pre-authorization required.
	Hospice services	25% coinsurance Deductible does not apply.	Not covered	Pre-authorization required.
If your child needs dental or eye care	Children’s eye exam	\$10 copay /visit. Deductible does not apply.	50% coinsurance	Limit 1 visit per benefit period.
	Children’s glasses	50% coinsurance . Deductible does not apply.	50% coinsurance	Limitations may apply.
	Children’s dental check-up	No charge. Deductible does not apply.	No charge. Deductible does not apply.	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](#).)

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic Surgery | <ul style="list-style-type: none"> • Elective abortions (except when provided to save the life of the mother) • Infertility Treatment • Long-term care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Weight loss programs |
|--|---|--|

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"> • Chiropractic care • Dental care (Adult) | <ul style="list-style-type: none"> • Hearing aids • Routine eye care (Adult) | <ul style="list-style-type: none"> • Routine foot care |
|--|--|---|

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

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, kwijigo 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.

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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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist (OB/GYN) copayment	\$0	■ Primary Care Physician copayment	\$0	■ Specialist copayment	\$10
■ Hospital (facility) copayment	25%	■ Hospital (facility) copayment	25%	■ Hospital (facility) copayment	25%
■ Other coinsurance	25%	■ Other coinsurance	25%	■ Other coinsurance	25%
<p>This EXAMPLE event includes services like: Specialist (OB/GYN) office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$0	Copayments	\$200	Copayments	\$30
Coinsurance	\$1,800	Coinsurance	\$200	Coinsurance	\$500
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$1,860	The total Joe would pay is	\$420	The total Mia would pay is	\$530

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