
 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](http://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:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>The overall medical <a href="#">deductible</a>: For In-Network Providers \$1,500 Individual or \$4,500 Family; for <a href="#">Out-of-Network Providers</a> \$5,000 Individual or \$15,000 Family</p>	<p>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 <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">Primary Care Provider</a> office visits and Wellness and <a href="#">preventive care</a> are not subject to the <a href="#">deductible</a>.</p>	<p>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>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Yes. For some <a href="#">Prescription Drug</a> tiers: \$500 Individual or \$1,500 Family. There are no other specific <a href="#">deductibles</a>.</p>	<p>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.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>For In-Network providers: \$6,700 Individual/\$13,400 Family.</p>	<p>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.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Copayments</a> and <a href="#">coinsurance</a> on certain services, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, <a href="#">cost sharing</a> for out-of-network, and health care this <a href="#">plan</a> does not cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://www.PrimewellHealth.com">www.PrimewellHealth.com</a> and click "Find a Provider" or call toll-free at (833) 798-1440 for a list of <a href="#">network providers</a>.</p>	<p>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.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

\* For more information about limitations and exceptions, see the plan or policy document at [www.PrimewellHealth.com](http://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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/</a> Immunization	No charge. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	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>	50% <a href="#">coinsurance</a>	Office lab is covered 100%. <a href="#">Deductible</a> may apply.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.PrimewellHealth.com">www.PrimewellHealth.com</a>	Tier 1 – Typically Generic Drugs	\$15 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	Not covered	This <a href="#">plan</a> 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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.PrimewellHealth.com/">www.PrimewellHealth.com/</a> .
	Tier 2 – Typically Preferred Brand Drugs	20% <a href="#">coinsurance</a>	Not covered	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3 – Typically Non-Preferred Brand Drugs	20% <a href="#">coinsurance</a>	Not covered	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 4 – Typically Specialty Drugs	50% <a href="#">coinsurance</a>	Not covered	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> 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	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Worldwide emergency coverage.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Emergency criteria required.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required on follow-up visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If you are pregnant	Office visits	\$20 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Copay</a> on initial visit only. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, 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>	<a href="#">Pre-authorization</a> required.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required.
If your child needs dental	Children's eye exam	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limit 1 visit per benefit period.

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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)	
or eye care	Children’s glasses	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Limitations may apply.
	Children’s dental check-up	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> 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.)**

- 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

**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](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 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**

\* For more information about limitations and exceptions, see the plan or policy document at [www.PrimewellHealth.com](http://www.PrimewellHealth.com).

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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\* For more information about limitations and exceptions, see the plan or policy document at [www.PrimewellHealth.com](http://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)		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)																																											
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■ <a href="#">Specialist</a> (OB/GYN) <a href="#">copayment</a>	\$20	■ <a href="#">Primary Care Physician</a> <a href="#">copayment</a>	\$20	■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	20%																																										
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\*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.