
 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:
<b>What is the overall <a href="#">deductible</a>?</b>	For In-Network Providers \$5,000 Individual or \$10,000 Family; for <a href="#">Out-of-Network Providers</a> \$5,000 Individual or \$15,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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> .	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You do not have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For In-Network providers: \$8,000 Individual/ \$16,000 Family.	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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> .	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

\* 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	\$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$80 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	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)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Lab and x-ray services performed in an office setting is covered at no charge. <a href="#">Deductible</a> may apply.
	Imaging (CT/PET scans, MRIs)	40% <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 <a href="#">Prescription Drugs</a>	\$20 <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 <a href="#">Prescription Drugs</a>	\$40 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply	Not covered	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3 <a href="#">Prescription Drugs</a>	\$80 <a href="#">copay</a> /prescription	Not covered	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 4 <a href="#">Prescription Drugs</a>	\$350 <a href="#">copay</a> /prescription	Not covered	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	Physician/surgeon fees	40% <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>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Worldwide emergency coverage.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Emergency criteria required.
	<a href="#">Urgent care</a>	\$60 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	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)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	Physician/surgeon fees	40% <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	\$40 <a href="#">copay</a> / office visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	None
	Inpatient services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If you are pregnant	Office visits	\$40 <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="#">deductible</a> , <a href="#">copay</a> , or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	Childbirth/delivery facility services	40% <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>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Hospice services</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required.

\* For more information about limitations and exceptions, see the plan or policy document at [www.PrimewellHealth.com](http://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 your child needs dental or eye care	Children’s eye exam	\$80 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	Limit 1 visit per benefit period.
	Children’s glasses	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	Limitations may apply.
	Children’s dental check-up	No charge. <a href="#">Deductible</a> does not apply.	No charge. <a href="#">Deductible</a> 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](#).

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

**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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,900	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,900	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,900																																										
■ <a href="#">Specialist</a> (OB/GYN) <a href="#">copayment</a>	\$40	■ <a href="#">Primary Care Physician</a> <a href="#">copayment</a>	\$40	■ <a href="#">Specialist</a> <a href="#">copayment</a>	\$80																																										
■ Hospital (facility) <a href="#">coinsurance</a>	40%	■ Hospital (facility) <a href="#">coinsurance</a>	40%	■ Hospital (facility) <a href="#">coinsurance</a>	40%																																										
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.