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 $3,000 Individual or $6,000 Family; 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: $6,400 Individual/$12,800 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	$40 copay. Deductible does not apply.	50% coinsurance	None
	Specialist visit	$80 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 aren't 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)	40% coinsurance	50% coinsurance	Lab and x-ray services performed in an office setting is covered at no charge. Deductible may apply.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	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	$20 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	$40 copay/prescription. Deductible does not apply.	Not covered	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3 Prescription Drugs	$80 copay/prescription	Not covered	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 4 Prescription Drugs	$350 copay/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% coinsurance	50% coinsurance	Pre-authorization required.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	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 immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	Worldwide emergency coverage.
	Emergency medical transportation	40% coinsurance	40% coinsurance	Emergency criteria required.
	Urgent care	$60 copay/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)	40% coinsurance	50% coinsurance	Pre-authorization required.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	Pre-authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/office visit. Deductible does not apply.	50% coinsurance	None
	Inpatient services	40% coinsurance	50% coinsurance	Pre-authorization required.
If you are pregnant	Office visits	$40 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	40% coinsurance	50% coinsurance	Pre-authorization required.
	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	Pre-authorization required.
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	Pre-authorization required.
	Rehabilitation services	$40 copay/visit. Deductible does not apply.	50% coinsurance	Pre-authorization required.
	Habilitation services	$40 copay/visit. Deductible does not apply.	50% coinsurance	Pre-authorization required.
	Skilled nursing care	40% coinsurance	50% coinsurance	Pre-authorization required.
	Durable medical equipment	40% coinsurance	50% coinsurance	Pre-authorization required.
	Hospice services	40% coinsurance	Not covered	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 your child needs dental or eye care	Children's eye exam	$80 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.)

- 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* 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*.

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**	**$5,700**
■ **Specialist (OB/GYN) copayment**	**$40**
■ **Hospital (facility) coinsurance**	**40%**
■ **Other coinsurance**	**40%**

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	$5,700
Copayments	$40
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,300**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	**$5,700**
■ **Primary Care Physician copayment**	**$40**
■ **Hospital (facility) coinsurance**	**40%**
■ **Other coinsurance**	**40%**

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	$900
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$5,700**
■ **Specialist copayment**	**$80**
■ **Hospital (facility) coinsurance**	**40%**
■ **Other coinsurance**	**40%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

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