




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, [www.myTrustmarkBenefits.com](http://www.myTrustmarkBenefits.com) or call 1-866-280-4120. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><a href="#">Preferred provider</a>: \$300/individual or \$900/family per calendar year.</p> <p><a href="#">Nonpreferred provider</a>: \$1,500 / individual or \$4,500 / family per calendar year.</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.</p> <p>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><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. Emergency treatment in the emergency room, and the following services by a preferred <a href="#">provider</a>: <a href="#">Preventive care</a>, and some office services, are covered before you meet your <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><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p><a href="#">Preferred provider</a>: \$3,000/individual or \$6,000/family per calendar year.</p> <p><a href="#">Nonpreferred provider</a>: \$7,500/individual or \$15,000/family per calendar year.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.</p> <p>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><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p>Penalties for failure to obtain <a href="#">precertification</a> for services, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myTrustmarkBenefits.com">www.myTrustmarkBenefits.com</a> or call 1-866-280-4120 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a referral.

 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
		Preferred Provider (You will pay the least)	Nonpreferred 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	\$25 <a href="#">copay</a> /visit ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Includes: Chiropractic & Acupuncture care. Maximum: \$1,000 combined per calendar year.
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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)	\$30 <a href="#">copay</a> /test ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a> /test ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> or call 1-800-776-1355.</p>	Generic drugs	Retail: \$10 <a href="#">copay</a> /prescription ( <a href="#">deductible</a> does not apply)	Retail: \$10 <a href="#">copay</a> /prescription ( <a href="#">deductible</a> does not apply)	<p><a href="#">Copay</a> applies to a 30-day supply Retail and Specialty drugs or 90 day supply Mail-Order prescription.</p> <p><a href="#">Copay</a> does not apply to preventive drugs required by the Affordable Care Act.</p> <p>If you use a non-participating pharmacy, you must also pay the difference in cost between a participating and the non-participating pharmacy.</p> <p>Specialty drugs are limited to a 30 day supply. First 2 fills allowed at retail; thereafter, additional fills must be made through the CVS Caremark Specialty Pharmacy Program.</p> <p>Compound drugs over \$300 and all specialty drugs require prior authorization.</p>
	Preferred brand drugs	Mail Order: \$10 <a href="#">copay</a> /prescription order ( <a href="#">deductible</a> does not apply)	Mail Order: Not Covered	
		Retail: The greater of a \$20 <a href="#">copay</a> or 15%, up to a maximum <a href="#">copay</a> of \$200	Retail: The greater of a \$20 <a href="#">copay</a> or 15%, up to a maximum <a href="#">copay</a> of \$200	
<a href="#">Specialty drugs</a>	Mail Order: The greater of a \$20 <a href="#">copay</a> or 15%, up to a maximum <a href="#">copay</a> of \$300	Mail Order: Not Covered	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	Outpatient Facility: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Outpatient Facility: \$130 <a href="#">copay</a> , then 50% after <a href="#">deductible</a>	<p><a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a>, benefits could be reduced by 50% of the total cost of the service.</p>
		Ambulatory Surgery/Surgery Center: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Ambulatory Surgery/Surgery Center: \$500 <a href="#">copay</a> , then 50% after <a href="#">deductible</a>	
	Physician/surgeon fees	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> ( <a href="#">deductible</a> does not apply)	<a href="#">Preferred provider</a> benefit applies.	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preferred provider</a> benefit applies.	None.
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$300 <a href="#">copay</a> then 50% <a href="#">coinsurance</a> , after <a href="#">deductible</a>	<a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	In Office: \$25 <a href="#">copay</a> /visit ( <a href="#">deductible</a> does not apply) and 10% <a href="#">coinsurance</a> for other outpatient services	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	Inpatient services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$300 <a href="#">copay</a> then 50% <a href="#">coinsurance</a> , after <a href="#">deductible</a>	<a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	First prenatal visit: No Charge \$25 <a href="#">copay</a> thereafter ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Dependent daughters are covered for this benefit. <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> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$300 <a href="#">copay</a> then 50% <a href="#">coinsurance</a> , after <a href="#">deductible</a>	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maximum: 100 visits/calendar year. <a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , benefits could be reduced by 50% of the total cost of the service.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /visit ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maximum: 60 days per confinement. <a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , benefits could be reduced by 50% of the total cost of the service.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Precertification</a> is required for inpatient services. If you don't get <a href="#">precertification</a> , benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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

## 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](#).)

- Cosmetic surgery
- Dental care
- Infertility treatment (diagnostic testing will be covered up to the max. of \$5,000 per covered person)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture (Max: \$1,000 combined with chiropractic services per calendar year)
- Bariatric surgery
- Chiropractic care (Max: \$1,000 combined with acupuncture services per calendar year)
- Habilitation services
- Hearing aids (Max: 1/ear every 3 years limit)
- Non-emergency care when traveling outside the U.S. (limited to employee's traveling for the business of the employer)
- Private-duty nursing

**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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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 the 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 1-866-280-4120.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-280-4120.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-280-4120.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-280-4120.

*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)

- The [plan's](#) overall [deductible](#) \$300
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,960</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$300
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$2,700
<a href="#">Coinsurance</a>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,020</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$300
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$900</b>

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