




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. 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 1-877-267-2323 extension 61565 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network provider : \$1,400 / individual or \$2,800 / family Out-of-network provider : \$3,000 / individual or \$5,500 / 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Preventive care , physician office visits, prescription drugs , and certain emergency services are covered before you meet your 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Network provider : \$3,475 / individual or \$6,950 / family Out-of-network provider : \$9,000 / individual or \$17,500 / 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit ?	Penalties for failure to obtain preauthorization for services, premiums , balance-billing charges, and health care this plan doesn't 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.myTrustmarkBenefits.com or call 1-800-999-0114 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	No.	You can see the specialist 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
		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	20% coinsurance	50% coinsurance	None.
	Specialist visit	20% coinsurance	50% coinsurance	Chiropractic care limited to 24 visits per plan year.
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check your plan .
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Precertification is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.navitus.com .	Generic drugs	\$15 copay after deductible for retail \$30 copay after deductible for mail order		Copay applies to a 30-day supply Retail and Specialty drugs or 31-90 day supply Mail-Order prescription. Copay does not apply to preventive drugs required by the Affordable Care Act. If you purchase a brand name drug when the physician has indicated a generic drug can be dispensed, you must pay difference in cost.
	Preferred brand drugs	\$50 copay after deductible for retail \$100 copay after deductible for mail order		
	Non-preferred brand drugs	\$50 copay after deductible for retail \$100 copay after deductible for mail order		
	Specialty drugs	20% coinsurance up to a \$500 maximum		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.myTrustmarkBenefits.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	20% coinsurance	Preferred provider benefit applies.	Non-emergency use of the emergency room is not covered.
	Emergency medical transportation	20% coinsurance	Preferred provider benefit applies.	None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Precertification is required. If precertification is not obtained, benefits will be reduced by \$400.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Precertification is required for intensive outpatient treatment (4 up to 6 hours) and applied behavioral analysis (ABA).
	Inpatient services	20% coinsurance	50% coinsurance	Precertification is required. If precertification is not obtained, benefits will be reduced by \$400.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of service, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (like an ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Precertification is required. If precertification is not obtained, benefits will be reduced by \$400.
	Rehabilitation services	20% coinsurance	50% coinsurance	Physical/occupational/speech therapy limited to 60 visits per plan year.
	Habilitation services	Not covered	Not covered	Not covered .
	Skilled nursing care	20% coinsurance	20% coinsurance	Limited to 120 days per plan year. Precertification is required. If precertification is not obtained, benefits will be reduced by \$400.
	Durable medical equipment	20% coinsurance	20% coinsurance	Precertification is required for equipment exceeding \$2,500.
	Hospice services	0% coinsurance	0% coinsurance	Precertification is required. If precertification is not obtained, benefits will be reduced by \$400.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

* For more information about limitations and exceptions, see the [plan](#) or policy document at 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
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Private-duty nursing
- Routine foot care
- Weight loss programs

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. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 1-800-999-0114.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-999-0114.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-999-0114.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-999-0114.

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](#) \$1,350
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$0
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,510

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,350
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$700
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,270

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,350
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$10
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,660

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