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 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:
What is the overall deductible?	Preferred provider: $250/individual or $750/family per calendar year. Nonpreferred provider: $750 / individual or $2,250 / family per calendar year.	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. Emergency treatment in the emergency room, and the following services by a preferred provider: Preventive care, and some office 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?	Preferred provider: $2,500/individual or $5,000/family per calendar year. Nonpreferred provider: $6,000/individual or $12,000/family per calendar year.	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?	Penalties for failure to obtain precertification 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.myTrustmarkBenefits.com or call 1-866-280-4120 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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit (deductible does not apply)	20% coinsurance after deductible	None.
	Specialist visit	$40 copay/visit (deductible does not apply)	20% coinsurance after deductible	Includes: Chiropractic & Acupuncture care. Maximum: $1,000 combined per calendar year.
	Preventive care/screening/ immunization	No charge	20% coinsurance after deductible	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)	$25 copay/test (deductible does not apply)	20% coinsurance after deductible	None.
	Imaging (CT/PET scans, MRIs)	$100 copay/test (deductible does not apply)	20% coinsurance after deductible	None.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-800-776-1355.	Generic drugs	Retail: $10 copay/prescription (deductible does not apply)	Retail: $10 copay/prescription (deductible does not apply)	Copay applies to a 30-day supply Retail and Specialty drugs or 90 day supply Mail-Order prescription. Copay does not apply to preventive drugs required by the Affordable Care Act. If you use a non-participating pharmacy, you must also pay the difference in cost between a participating and the non-participating pharmacy. 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. Compound drugs over $300 and all specialty drugs require prior authorization.
		Mail Order: $10 copay/prescription order (deductible does not apply)	Mail Order: Not Covered	
	Preferred brand drugs	Retail: The greater of a $20 copay or 15%, up to a maximum copay of $200	Retail: The greater of a $20 copay or 15%, up to a maximum copay of $200	
		Mail Order: The greater of a $20 copay or 15%, up to a maximum copay of $300	Mail Order: Not Covered	
	Specialty drugs	Same as above	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Outpatient Facility: $250 copay then 0% coinsurance after deductible	Outpatient Facility: $130 copay then 20% coinsurance after deductible	Precertification is required. If you don't get precertification, benefits could be reduced by 50% of the total cost of the service.
		Ambulatory Surgery/Surgery Center: $250 copay then 0% coinsurance after deductible	Ambulatory Surgery/Surgery Center: $500 copay then 50% coinsurance after deductible	
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	None.

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	Emergency room care	$150 copay (deductible does not apply)	Preferred provider benefit applies.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance after deductible	Preferred provider benefit applies.	None.
	Urgent care	$25 copay/visit (deductible does not apply)	20% coinsurance after deductible	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay (deductible does not apply)	$300 copay then 20% coinsurance after deductible	Precertification is required. If you don't get precertification, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	In Office: $25 copay/visit (deductible does not apply) and 0% coinsurance after deductible for other outpatient services	20% coinsurance after deductible	None.
	Inpatient services	$1,000 copay (deductible does not apply)	$300 copay then 20% coinsurance after deductible	Precertification is required. If you don't get precertification, 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 copay (deductible does not apply) thereafter	20% coinsurance after deductible	Dependent daughters are covered for this benefit. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance after deductible	
	Childbirth/delivery facility services	$1,000 copay (deductible does not apply)	$300 copay then 20% coinsurance after deductible	

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	Home health care	0% coinsurance after deductible	20% coinsurance after deductible	Maximum: 100 visits/calendar year. Precertification is required. If you don't get precertification, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	$40 copay/visit (deductible does not apply)	20% coinsurance after deductible	None.
	Habilitation services	$40 copay/visit (deductible does not apply)	20% coinsurance after deductible	None.
	Skilled nursing care	0% coinsurance after deductible	20% coinsurance after deductible	Maximum: 60 days per confinement. Precertification is required. If you don't get precertification, benefits could be reduced by 50% of the total cost of the service.
	Durable medical equipment	0% coinsurance after deductible	20% coinsurance after deductible	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	0% coinsurance after deductible	20% coinsurance after deductible	Precertification is required for inpatient services. If you don't get precertification, 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.

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. 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 1-866-280-4120.

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, kwiijigo holne' 1-866-280-4120.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

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	$250
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$2,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$250
Copayments	$2,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,520**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$250
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**

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