




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:
<b>What is the overall <a href="#">deductible</a>?</b>	<p><a href="#">Preferred provider</a>: \$2,800/individual or \$5,200/family per calendar year.</p> <p><a href="#">Nonpreferred provider</a>: \$5,200 / individual or \$10,400 / 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>
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	<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>
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<p><a href="#">Preferred provider</a>: \$5,200/individual or \$7,900/family per calendar year.</p> <p><a href="#">Nonpreferred provider</a>: \$10,400/individual or \$20,800/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. 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>
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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> 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 & Mail Order: <a href="#">Deductible</a> then \$10 <a href="#">copay</a> /prescription	Retail: <a href="#">Deductible</a> then \$10 <a href="#">copay</a> /prescription	<a href="#">Copay</a> applies to a 30-day supply Retail and Specialty drugs or 90 day supply Mail-Order prescription.
	Preferred brand drugs	Retail: The greater of a \$20 <a href="#">copay</a> or 15%, up to a maximum <a href="#">copay</a> of \$200/prescription after <a href="#">deductible</a>  Mail Order: The greater of a \$20 <a href="#">copay</a> or 15%, up to a maximum <a href="#">copay</a> of \$300/prescription after <a href="#">deductible</a>	Retail: The greater of a \$20 <a href="#">copay</a> or 15%, up to a maximum <a href="#">copay</a> of \$200/prescription after <a href="#">deductible</a>	<a href="#">Copay</a> does not apply to preventive drugs required by the Affordable Care Act.
			Mail Order: Not Covered	If you use a non-participating pharmacy, you must also pay the difference in cost between a participating and the non-participating pharmacy.
<a href="#">Specialty drugs</a>	Same as above	Not covered	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.	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% <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. 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	20% <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>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preferred provider</a> benefit applies.	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preferred provider</a> benefit applies.	None.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <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. 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	20% <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	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	Inpatient services	20% <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. 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 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <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>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Skilled nursing care</a>	20% <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>	20% <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>	20% <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.
<b>If your child needs dental or eye care</b>	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](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](#) \$2,800
- [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*)

<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>	\$2,800
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,870</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,800
- [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*)

<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>	\$1,900
<a href="#">Copayments</a>	\$2,700
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,620</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,800
- [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*)

<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>	\$2,800
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,810</b>

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