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, see www.myTrustmarkBenefits.com and/or call **1-877-498-8937**. 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 **1-877-498-8937** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500** individual / **$5,000** family per calendar year Coinsurance and copays do not apply to the deductible. This benefit combines your prescription drug and medical deductible.	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?	Yes. Preventive care is 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?	**$3,500** individual / **$7,000** family per calendar year – medical and prescription drug combined **$1,350** individual / **$2,700** family per calendar year – prescription drug only	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?	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 preferred provider?	Yes. See www.myTrustmarkBenefits.com or call **1-877-498-8937** for a list of preferred 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 non-preferred 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 preferred provider might use an non-preferred 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)	Non-Preferred 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	10% coinsurance	10% coinsurance	Some services require prior authorization.
	Specialist visit	10% coinsurance	10% coinsurance	Some services require prior authorization.
	Preventive care/screening/ immunization	No Charge	No Charge	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)	10% coinsurance	10% coinsurance	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	Prior authorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at - **www.optumrx.com** or call **1 800-788-4863**. This plan follows the OptumRx Select Formulary.	Generic drugs	10% coinsurance	Not Covered	30-day supply - retail / 90-day supply - mail order Preferred provider wellness drugs are covered with no charge. Some prescriptions require prior authorization.
	Preferred brand drugs	10% coinsurance	Not Covered	
	Non-preferred brand drugs	10% coinsurance	Not Covered	
	Specialty drugs	10% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	Prior authorization required for certain surgeries.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	Prior authorization required for certain surgeries.
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Must meet emergency criteria.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Must meet emergency criteria.
	Urgent care	10% coinsurance	10% coinsurance	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	Prior authorization required.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	Prior authorization required.
If you need mental health,	Outpatient services	10% coinsurance	10% coinsurance	Some services require prior authorization.

* 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*
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
behavioral health, or substance abuse services	Inpatient services	10% coinsurance	10% coinsurance	Prior authorization required. Includes facility and physician fees.
If you are pregnant	Office visits	10% coinsurance	10% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Special Delivery program available through Optum Health.
	Childbirth/delivery professional services	10% coinsurance	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	10% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	Prior authorization required.
	Rehabilitation services	10% coinsurance	Not Covered	Prior authorization required after 5 visits. 30 combined visits for physical, speech and occupational therapy
	Habilitation services	10% coinsurance	Not Covered	
	Skilled nursing care	10% coinsurance	Not Covered	Prior authorization required.
	Durable medical equipment	10% coinsurance	10% coinsurance	Prior authorization required for certain equipment.
	Hospice services	10% coinsurance	10% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	$20 copay (deductible does not apply)	Payment up to the allowed amount less the $20 copay (deductible does not apply)	One routine exam per calendar year.
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	None.

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
- Cosmetic surgery (except with prior authorization for reconstruction)
- Dental care (adult/child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (except for treatment of diabetes)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Infertility medications
- Private-duty nursing
- Routine eye care (adult/child)

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 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 **1-877-498-8937**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [**1-877-498-8937**.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码 1-877-498-8937**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-877-498-8937**

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.myTrustmarkBenefits.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 preferred pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist coinsurance	10%
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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

Managing Joe's type 2 Diabetes
(a year of routine preferred care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist coinsurance	10%
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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$718
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,273**

Mia's Simple Fracture
(preferred emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist coinsurance	10%
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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,733
Copayments	$0
Coinsurance	$193
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,926**

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