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 1-877-498-8937 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred provider: $1,000 / individual or $2,000 / family per calendar year Nonpreferred provider: 2,000 / individual or $4,000 / 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. Preventive care, office visits, and urgent care visits, and non-preferred preventive mammography screenings 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?	Yes. **$100** individual for prescription drug coverage.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Preferred provider:: $3,500 individual / $7,000 family per calendar year. Nonpreferred provider: $7,000 individual / $14,000 family per calendar year. Medical and prescription drug out-of-pocket limits are separate. $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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
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 network 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 a 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)	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/office visit and 20% coinsurance for other office services; deductible does not apply	30% coinsurance	Some services require prior authorization.
	Specialist visit	$40 copay/visit and 20% coinsurance for other office services; deductible does not apply	30% 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)	20% coinsurance	30% coinsurance	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Prior authorization required.

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.optumrx.com** or call **1 800-788-4863.** This plan follows the OptumRx Select Formulary.	Generic drugs	$15 copay after $100 prescription drug deductible / prescription retail & $30 copay after $100 prescription drug deductible / prescription mail order	Not Covered	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 a generic drug is available, you must pay difference in cost. Some prescriptions require prior authorization. Specialty drugs must be filled at Optum Specialty. For more information, visit http://specialty.optumrx.com/ or call Optum Specialty at 1-844-265-1761.
	Preferred brand drugs	$30 copay after $100 prescription drug deductible / prescription retail & $60 copay after $100 prescription drug deductible / prescription mail order	Not Covered	
	Non-preferred brand drugs	$45 copay after $100 prescription drug deductible / prescription retail & $90 copay after $100 prescription drug deductible / prescription mail order	Not Covered	
	Specialty drugs	Same as retail copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Prior authorization required for certain surgeries.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Prior authorization required for certain surgeries.
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.	Must meet emergency criteria.
	Urgent care	$40 copay/visit deductible does not apply	$40 copay/visit deductible does not apply	Applies to urgent care facilities.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit and 20% coinsurance for other office services; deductible does not apply	30% coinsurance	Some services require prior authorization.
	Inpatient services	20% coinsurance	30% coinsurance	Prior authorization required. Includes facility and physician fees.
If you are pregnant	Office visits	$25 copay/office visit and 20% coinsurance for other office services; deductible does not apply	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment, 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	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Prior authorization required.
	Rehabilitation services	20% coinsurance	Not Covered	Prior authorization required after 5 visits. 30 combined visits for physical, speech and occupational therapy in a calendar year.
	Habilitation services	20% coinsurance	Not Covered	
	Skilled nursing care	20% coinsurance	Not Covered	Prior authorization required.
	Durable medical equipment	20% coinsurance	30% coinsurance	Prior authorization required for certain equipment.
	Hospice services	20% coinsurance	30% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	$20 copay/office visit, deductible does not apply	Payment up to the allowed amount less the $20 copay/office visit, 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
- Habilitation services
- 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 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 1-877-498-8937.
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 in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$40
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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,360**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,100
Copayments	$800
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,930**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1.000
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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