




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). 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 888-604-9397 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">Preferred provider</a> : \$0 / individual or \$0 / family per calendar year. <a href="#">Nonpreferred provider</a> : \$1,000 / individual or \$3,000 / family per calendar year	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. 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Services by a <a href="#">preferred provider</a> are covered before you meet your <a href="#">deductible</a>	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$500 for mental health and substance abuse treatment by a <a href="#">Nonpreferred provider</a> This <a href="#">deductible</a> is included in the overall <a href="#">deductible</a>	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">Preferred provider</a> & <a href="#">Nonpreferred provider</a> combined <a href="#">out-of-pocket limit</a> . Medical: \$4,650 / individual or \$9,300 / family per calendar year Prescriptions: \$2,500 / individual or \$5,000 / family per calendar year	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties for failure to obtain <a href="#">preauthorization</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

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- 888-604-9397 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 <a href="#">referral</a> .

 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	\$25 <a href="#">copay</a> /visit	\$25 <a href="#">copay</a> /visit then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /visit	\$25 <a href="#">copay</a> /visit then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge	\$25 <a href="#">copay</a> /visit then 20% <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. Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Outpatient radiology center/Lab/Office: \$25 <a href="#">copay</a>  Outpatient hospital: \$50 <a href="#">copay</a>  Quest Laboratory: \$5 <a href="#">copay</a>	Outpatient radiology center/Lab/Office: \$25 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>  Outpatient hospital: \$85 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .

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 test	Imaging (CT/PET scans, MRIs)	Outpatient radiology center: \$25 <a href="#">copay</a>	Outpatient radiology center: \$25 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
		Outpatient hospital: \$50 <a href="#">copay</a>	Outpatient hospital: \$85 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.empirxhealth.com">www.empirxhealth.com</a> or call 1-877-241-7123.	Generic drugs	Retail 30 day supply: \$5 <a href="#">copay</a> / prescription Mail order or Retail 90 day supply: \$10 <a href="#">copay</a> / prescription		<a href="#">Coinsurance</a> 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 the copay plus the difference in cost. <a href="#">Specialty drugs</a> are limited to a 30 day Supply.
	Preferred brand drugs	Retail 30 day supply: \$35 <a href="#">copay</a> / prescription Mail order or Retail 90 day supply: \$70 <a href="#">copay</a> / prescription		
	Non-preferred brand drugs	Retail 30 day supply: \$60 <a href="#">copay</a> / prescription Mail order or Retail 90 day supply: \$120 <a href="#">copay</a> / prescription		
	<a href="#">Specialty drugs</a>	Preferred Brand \$35 <a href="#">copay</a> / prescription Non-preferred Brand \$60 <a href="#">copay</a> / prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 <a href="#">copay</a>	\$85 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for certain outpatient procedures. If <a href="#">preauthorization</a> is not obtained, benefits could be reduced by \$500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
	Physician/surgeon fees	\$25 <a href="#">copay</a>	\$25 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .

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>	Emergency Care: \$100 <a href="#">copay</a>  Non-Emergency Care: \$100 <a href="#">copay</a>	Emergency Care: <a href="#">Preferred provider</a> benefit applies.  Non-Emergency Care: \$120 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Emergency room care copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	\$70 <a href="#">copay</a>	<a href="#">Preferred provider</a> benefit applies.	None.
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a>	\$45 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <a href="#">copay</a> per admission	\$500 <a href="#">copay</a> per admission then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, benefits could be reduced by \$500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
	Physician/surgeon fees	No Charge	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a>	\$25 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after \$500 <a href="#">deductible</a>	Contact Quantum Health at (888)214-4001 for mental health, behavioral health and substance abuse services. <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, benefits could be reduced by \$500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
	Inpatient services	\$100 <a href="#">copay</a> per admission	\$500 <a href="#">copay</a> per admission then 20% <a href="#">coinsurance</a> after \$500 <a href="#">deductible</a>	
If you are pregnant	Office visits	Initial Visit: \$25 <a href="#">copay</a> Routine prenatal and initial postnatal: 0% <a href="#">coinsurance</a>	\$25 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Dependent daughters are covered for this benefit. <a href="#">Preauthorization</a> is required for routine and

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)	
	Childbirth/delivery professional services	\$25 <a href="#">copay</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	high risk maternity (routine only if inpatient stay exceeds federal requirements). If <a href="#">preauthorization</a> is not obtained, benefits could be reduced by \$500 of the total cost of the service. <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> and <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
	Childbirth/delivery facility services	\$100 <a href="#">copay</a> per admission	\$500 <a href="#">copay</a> per admission then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Limited to 180 visits per calendar year. <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, benefits could be reduced by \$500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copay</a>	\$25 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	None.
	<a href="#">Skilled nursing care</a>	\$100 <a href="#">copay</a> per admission	\$500 <a href="#">copay</a> per admission then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	180 days per calendar year. <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained, benefits could be reduced by \$500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .

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)	
	<a href="#">Durable medical equipment</a>	\$25 <a href="#">copay</a>	\$25 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for equipment over \$1500 (except insulin pumps). If <a href="#">preauthorization</a> is not obtained, benefits could be reduced by \$500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
	<a href="#">Hospice services</a>	No Charge	No Charge	<a href="#">Preauthorization</a> is required for inpatient services. If <a href="#">preauthorization</a> is not obtained, benefits could be reduced by \$500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customary from an <a href="#">out-of-network provider</a> .
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None.
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Chiropractic Care (prior authorization required)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids</li> <li>• Infertility Treatment (limitations apply)</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing (only covered as part of home health care services)</li> </ul>



**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 1-888-604-9397.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-604-9397.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-604-9397.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-604-9397.

*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](#) \$0
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 100%
- Other [coinsurance](#) 100%

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>	\$0
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$660</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 100%
- Other [coinsurance](#) 100%

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>	\$0
<a href="#">Copayments</a>	\$1,300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,320</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 100%
- Other [coinsurance](#) 100%

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>	\$0
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>

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