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 888-604-9397 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred provider: $0 / individual or $0 / family per calendar year. Nonpreferred provider: $1,000 / individual or $3,000 / 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. Services by a preferred provider 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. $500 for mental health and substance abuse treatment by a Nonpreferred provider This deductible is included in the overall deductible	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 & Nonpreferred provider combined out-of-pocket limit . Medical: $4,650 / individual or $9,300 / family per calendar year Prescriptions: $2,500 / individual or $5,000 / 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 preauthorization 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.mytrustmarkbenefits.com or call 1- 888-604-9397for 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 Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	$25 copay/visit then 25% coinsurance after deductible	Member may be billed for charges in excess of Usual & Customary from an out-of-network provider.
	Specialist visit	$25 copay/visit	$25 copay/visit then 25% coinsurance after deductible	Member may be billed for charges in excess of Usual & Customary from an out-of-network provider.
	Preventive care / screening / immunization	No charge	$25 copay/visit then 25% 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. Member may be billed for charges in excess of Usual & Customary from an out-of-network provider.
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient radiology center/Lab/Office: $25 copay Outpatient hospital: $50 copay Quest Laboratory: $5 copay	Outpatient radiology center/Lab/Office: $25 copay then 25% coinsurance after deductible Outpatient hospital: $85 copay then 25% coinsurance after deductible	Member may be billed for charges in excess of Usual & Customary from an out-of-network provider.

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a test	Imaging (CT/PET scans, MRIs)	Outpatient radiology center: $25 copay Outpatient hospital: $50 copay	Outpatient radiology center: $25 copay then 25% coinsurance after deductible Outpatient hospital: $85 copay then 25% coinsurance after deductible	Member may be billed for charges in excess of Usual & Customary from an out-of-network provider.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empirxhealth.com or call 1-877-241-7123.	Generic drugs	Retail 30 day supply: $5 copay/ prescription Mail order or Retail 90 day supply: $10 copay/ prescription		Coinsurance 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. Specialty drugs are limited to a 30 day Supply.
	Preferred brand drugs	Retail 30 day supply: $35 copay/ prescription Mail order or Retail 90 day supply: $70 copay/ prescription		
	Non-preferred brand drugs	Retail 30 day supply: $60 copay/ prescription Mail order or Retail 90 day supply: $120 copay/ prescription		
	Specialty drugs	Preferred Brand $35 copay/ prescription Non-preferred Brand $60 copay/ prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay	$85 copay then 25% coinsurance after deductible	Preauthorization is required for certain outpatient procedures. If preauthorization 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 out-of-network provider.
	Physician/surgeon fees	$25 copay	$25 copay then 25% coinsurance after deductible	Member may be billed for charges in excess of Usual & Customary from an out-of-network provider.

Common Medical Event	Services You May Need	What You Will Pay: Preferred Provider (You will pay the least)	What You Will Pay: Nonpreferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	Emergency Care: $100 copay Non-Emergency Care: $100 copay	Emergency Care: Preferred provider benefit applies. Non-Emergency Care: $120 copay then 25% coinsurance after deductible	Emergency room care copay waived if admitted.
	Emergency medical transportation	$70 copay	Preferred provider benefit applies.	None.
	Urgent care	$35 copay	$45 copay then 25% coinsurance after deductible	Member may be billed for charges in excess of Usual & Customary from an out-of-network provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per admission	$500 copay per admission then 25% coinsurance after deductible	Preauthorization is required. If preauthorization 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 out-of-network provider.
	Physician/surgeon fees	No Charge	25% coinsurance after deductible	Member may be billed for charges in excess of Usual & Customary from an out-of-network provider.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay	$25 copay then 25% coinsurance after $500 deductible	Contact Quantum Health at (888)214-4001 for mental health, behavioral health and substance abuse services. Preauthorization is required. If preauthorization 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 out-of-network provider.
	Inpatient services	$100 copay per admission	$500 copay per admission then 25% coinsurance after $500 deductible	
If you are pregnant	Office visits	Initial Visit: $25 copay Routine prenatal and initial postnatal: 0% coinsurance	$25 copay then 25% coinsurance after deductible	Dependent daughters are covered for this benefit. Preauthorization is required for routine and

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Nonpreferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery professional services	$25 copay	25% coinsurance after deductible	high risk maternity (routine only if inpatient stay exceeds federal requirements). If preauthorization is not obtained, benefits could be reduced by $500 of the total cost of the service. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance and deductible 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 out-of-network provider.
	Childbirth/delivery facility services	$100 copay per admission	$500 copay per admission then 25% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No Charge	25% coinsurance after deductible	Limited to 180 visits per calendar year. Preauthorization is required. If preauthorization 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 out-of-network provider.
	Rehabilitation services	$25 copay	$25 copay then 25% coinsurance after deductible	Member may be billed for charges in excess of Usual & Customary from an out-of-network provider.
	Habilitation services	Not Covered	Not Covered	None.
	Skilled nursing care	$100 copay per admission	$500 copay per admission then 25% coinsurance after deductible	180 days per calendar year. Preauthorization is required. If preauthorization 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 out-of-network provider.

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Nonpreferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	$25 copay	$25 copay then 25% coinsurance after deductible	Preauthorization is required for equipment over $1500 (except insulin pumps). If preauthorization 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 out-of-network provider.
	Hospice services	No Charge	No Charge	Preauthorization is required for inpatient services. If preauthorization 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 out-of-network provider.
If your child needs dental or eye care	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 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 (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Bariatric surgery
- Chiropractic Care (prior authorization required)
- Hearing Aids
- Infertility Treatment (limitations apply)
- Private-duty nursing (only covered as part of home health care services)

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 1-888-604-9397.

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, kwiijigo 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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$200**

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$405
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$405**

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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$255
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$255**

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