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 1-800-999-0114 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network provider: $500 / individual or $1,500 / family per plan year. Out-of-network provider: $1,000 / individual or $3,000 / family per plan year. Out-of-network deductible applies to network deductible and vice versa.	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. The following services by a network provider: office visits, preventive care, and urgent care 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.
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?	Network provider: $3,500 / individual or $10,500 / family per plan year. Out-of-network provider: $7,000 / individual or $21,000 / family per plan year. Out-of-network out-of-pocket applies to network out-of-pocket and vice versa.	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.
Will you pay less if you use a network provider?	Yes. See www.myTrustmarkBenefits.com or call 1-800-999-0114 for 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network 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 deductible does not apply	40% coinsurance	None
	Specialist visit	$50 copay/office visit deductible does not apply	40% coinsurance	Chiropractic visits limited to 30 visits/benefit period.
	Preventive care/screening/ immunization	No charge	40% coinsurance	In-network immunizations payable at 100% after $25 copay. 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	40% coinsurance	If performed and billed by a physician's office, please refer to Primary care visit and Specialist visit.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	If performed and billed by a physician's office, please refer to Primary care visit and Specialist visit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network 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.sonapharmacybenefits.com.	Generic drugs	$10 copay / prescription retail & $25 copay / prescription mail order	Not Covered	Copay applies up to a 34-day supply Retail and up to 90 day supply Retail or Mail-Order prescription. If you purchase a brand name drug when a generic drug is available, you must pay difference in cost PLUS your applicable copay.
	Preferred brand drugs	$30 copay / prescription retail & $75 copay / prescription mail order	Not Covered	
	Non-preferred brand drugs	$60 copay / prescription retail & $150 copay / prescription mail order	Not Covered	
	Specialty drugs	$60 copay / prescription retail	Not Covered	Specialty drugs limited to 30-day supply retail. Mail order is not available. Information on ordering Specialty drugs and dispensing limitation, contact Sona Benefits at 1-800-880-9988. Mail order not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance after $150 copay/office visit	Network provider benefit applies.	Copay waived if admitted or due to an accident.
	Emergency medical transportation	20% coinsurance	Network provider benefit applies.	Includes air transportation, if applicable
	Urgent care	$30 copay/office visit deductible does not apply	40% coinsurance	Separate facility copay of $30 applies.

* 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit deductible does not apply	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
If you are pregnant	Office visits	$25 copay/office visit deductible does not apply	40% coinsurance	Dependent daughters are not covered for this benefit. Preauthorization is required for extended stay. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical & occupational therapy limited to 30 visits combined/benefit period, speech therapy limited to 30 visits/benefit period. Preauthorization is required for inpatient. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	60 days/benefit period, combined with inpatient rehabilitation. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
	Durable medical equipment	20% coinsurance	40% coinsurance	Wigs limited to 1/lifetime after cancer treatment.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required for inpatient. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
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	See separate Dental Plan.

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- 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.)

- Chiropractic care
- Infertility treatment (diagnostic testing only)
- 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Contact Trustmark Health Benefits, Inc. at 1-800-999-0114 or visit us at www.myTrustmarkBenefits.com.

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.

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	$500
Specialist copayment	$50
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	$500
Copayments	$200
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	$500
Specialist copayment	$50
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	$800
Copayments	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

The plan's overall deductible	$500
Specialist copayment	$50
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	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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