




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 1-877-267-2323 extension 61565 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers : \$0 / individual or \$0 / family. Out-of-network providers : \$500 / individual or \$1,000 / family.	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. For out-of-network providers : prescription drugs and emergency room treatment 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers : \$7,350 / individual or \$14,700 / family. Out-of-network providers : \$4,000 / individual or \$8,000 / family.	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?	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.cofinity.net or call 1-800-831-1166 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	\$20 copay /office visit and no charge for other office services; deductible does not apply	20% coinsurance	None.
	Specialist visit	\$20 copay /office visit and no charge for other office services; deductible does not apply	20% coinsurance	38 visits in a calendar year for the combination of chiropractic care and massage therapy visits.
	Preventive care/screening/immunization	No charge	20% coinsurance	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)	No charge	20% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ehimrx.com .	Generic drugs	\$10 copay / prescription retail & prescription mail order		Deductible does not apply. 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 the physician has indicated a generic drug can be dispensed, you must pay difference in cost.
	Preferred brand drugs	\$40 copay / prescription retail & prescription mail order		
	Non-preferred brand drugs	\$80 copay / prescription retail & prescription mail order		

* 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)	
	Specialty drugs	\$80 copay / prescription retail & prescription mail order		Specialty drugs are limited to one month supply whether purchased through a retail pharmacy or mail order. Specialty drugs billed at more than \$2,500 requires precertification. Failure to call may result in a reduction of benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	None.
	Physician/surgeon fees	No Charge	20% coinsurance	None.
If you need immediate medical attention	Emergency room care	\$50 copay / visit deductible does not apply	\$50 copay / visit deductible does not apply	Copay waived if admitted. Non-emergency use of the emergency room is not covered.
	Emergency medical transportation	No Charge	No Charge	None.
	Urgent care	\$20 copay / visit deductible does not apply	\$20 copay / visit deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Pre-certification required. No penalty if not obtained.
	Physician/surgeon fees	No Charge	20% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay /office visit deductible does not apply and no charge for other outpatient services	20% coinsurance	None.
	Inpatient services	No Charge	20% coinsurance	Pre-certification required. No penalty if not obtained.
If you are pregnant	Office visits	\$20 copay /office visit deductible does not apply	20% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge	20% coinsurance	
	Childbirth/delivery facility services	No Charge	20% coinsurance	

* 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 need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance	Pre-certification required. No penalty if not obtained.
	Rehabilitation services	\$20 copay /office visit deductible does not apply	20% coinsurance	50 visits in a calendar year for the combination of occupational, physical and speech therapy.
	Habilitation services	\$20 copay /office visit deductible does not apply	20% coinsurance	50 visits in a calendar year for the combination of occupational, physical and speech therapy.
	Skilled nursing care	No Charge	20% coinsurance	Pre-certification required. No penalty if not obtained. 90 days in a calendar year.
	Durable medical equipment	No Charge	20% coinsurance	\$3,600 every 36 months for expenses relating to hearing aids.
	Hospice services	No Charge	20% coinsurance	365 days in a calendar year.
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 .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult) • Habilitative Services • 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • 	<ul style="list-style-type: none"> • Private-duty nursing • 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.)		
<ul style="list-style-type: none"> • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care 	<ul style="list-style-type: none"> • Hearing aides

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.myTrustmarkBenefits.com.

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800- 999-0114.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800- 999-0114.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800- 999-0114.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800- 999-0114.

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](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

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](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$920

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	200

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