




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 or call 1-855-494-9335. 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 1-855-494-9335 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>In-Network: \$600 individual / \$1,200 family, Out-of-Network: \$3,000 individual / \$6,000 family. Copayments and coinsurance do not count toward the network deductible.</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Office visits, preventive care services, urgent care, outpatient mental health / substance abuse, rehabilitation services and Phoebe Pharmacy prescription drug benefits are covered before you meet your deductible.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. \$125 individual for prescription drugs. Does not apply to Phoebe Pharmacy.</p>	<p>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.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p><u>Medical Coinsurance</u>: In-Network: \$0 individual / \$0 family; Out-of-Network: \$5,000 individual / \$10,000 family. <u>Total Out-of-Pocket</u> (includes deductible, coinsurance, and all copays under both medical and prescription drug). In-Network: \$8,700 individual / \$17,400 family; Out-of-Network: Unlimited.</p>	<p>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.</p>

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit ?	In-Network: 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 1-855-494-9335	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	\$30 copay /visit Deductible does not apply	40% coinsurance	None
	Specialist visit	\$40 copay /visit Deductible does not apply	40% coinsurance	Chiropractic care: Combined network and out-of-network: 20 visits per benefit period.
	Preventive care/screening /immunization	No charge	40% 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)	0% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	None

* 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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com .	Formulary and Non-Formulary Generic drugs	\$10 copay (30-day supply retail) \$25 copay (90-day supply – Phoebe Pharmacy only) Not Covered (mail order)	Not Covered	Up to 30-day supply retail pharmacy. Up to 90-day supply at Phoebe Pharmacy.
	Formulary Brand drugs	\$45 copay (30-day supply retail) \$95 copay (90-day supply – Phoebe Pharmacy only) Not Covered (mail order)	Not Covered	All maintenance medications are required to be filled through the Phoebe Pharmacy after the first fill at a non-Phoebe pharmacy and filled as a 90 day supply. Maintenance medications being filled at the Phoebe Pharmacy at a 30 day supply must be transitioned to a 90 day supply after the first fill.
	Non-Formulary Brand drugs	\$65 copay (30-day supply retail) \$140 copay (90-day supply – Phoebe Pharmacy only) Not Covered (mail order)	Not Covered	Not covered- maintenance prescription drugs through mail order. Copay does not apply to preventive drugs required by the Affordable Care Act.
	Specialty drugs	\$250 copay (Phoebe Pharmacy only) Not Covered (mail order)	Not Covered	Up to 30-day supply through the Phoebe Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	\$175 copay /visit Deductible does not apply	Network provider benefit applies.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	Network provider benefit applies.	None
	Urgent care	\$40 copay /visit Deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	Pre-certification may be required.

* 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)	
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay /visit Deductible does not apply	40% coinsurance	None
	Inpatient services	0% coinsurance	40% coinsurance	Pre-certification may be required.
If you are pregnant	Office visits	\$30 copay /visit Deductible does not apply	40% coinsurance	The first visit to determine pregnancy is covered at no charge.
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	Cost sharing does not apply for 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).
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	Pre-certification may be required. Combined network and out-of-network: 90 visits per benefit period.
	Rehabilitation services	\$40 copay /visit Deductible applies	40% coinsurance	Combined network and out-of-network: 20 physical therapy visits, 12 speech therapy visits, and 12 occupational therapy visits per benefit period.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	0% coinsurance	40% coinsurance	Pre-certification may be required. Combined network and out-of-network: 100 days per benefit period
	Durable medical equipment	0% coinsurance	40% coinsurance	None
	Hospice services	0% coinsurance	40% coinsurance	Pre-certification may be required. Combined network and out-of-network: 10 days per lifetime or 240 hours/lifetime for respite care
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

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

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 | • Habilitation Services | • Routine Eye Care |
| • Cosmetic Surgery | • Infertility Treatment | • Routine Foot Care |
| • Dental Care | • Long-term Care | • Weight Loss Programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|--|--------------------------------------|--|
| • Bariatric Surgery | • Coverage provided outside the U.S. | • Non-emergency care when traveling outside the U.S. |
| • Chiropractic Care (20 visits per benefit period) | • Infertility Treatment | • 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 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 1-855-494-9335.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-494-9335.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-494-9335.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-494-9335.

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	\$600
■ Specialist copayment	\$40
■ 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	\$600
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$660

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$600
■ Specialist copayment	\$40
■ 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	\$600
Copayments	\$1300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1920

Mia's Simple Fracture

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

■ The plan's overall deductible	\$600
■ Specialist copayment	\$40
■ 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	\$600
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1100

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