Trustmark Services Company: Qualified High Deductible Health Plan – Premier Option

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage Period: 01/01/2017 – 12/31/2017**

Coverage for: Employee, Employee + Spouse, Employee + Child(ren), Family | **Plan Type:** High Deductible

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document on the Virtual Water Cooler at https://my.trustmarkcompanies.com/wps/myportal/virtualwatercooler or by calling 1-877-367-5690. You may also access the Uniform Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** individual **/$3,000** aggregate family for **preferred providers** and **$3,000** individual **/$6,000** aggregate family for **non-preferred providers**. Doesn't apply to preventive care. **Copayments** and **coinsurance** do not apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. The **preferred provider** and **non-preferred provider deductibles** accumulate separately.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$4,250** individual **/$8,500** aggregate family* for **preferred providers** and **$8,500** individual/ **$17,000** aggregate family for **non-preferred providers**. *No individual will have more than a $6,850 **preferred provider** Out of Pocket expense	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The **preferred provider** and **non-preferred provider out–of–pocket limits** accumulate separately.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties for failing to obtain required precertification and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.aetna.com or call **800-US-AETNA**; www.ipnmd.com or call **208-333-1513;** www.medcost.com or call **800-824-7406**; or www.preferredone.com or call **800-451-9597** for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Specialist visit	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Other practitioner office visit	20% **coinsurance**	40% **coinsurance**	Chiropractic care limited to 25 visits per year. **Non-preferred providers** limited to customary and reasonable amount.
	Preventive care/screening/ immunization	No charge	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com 1-866-644-7527.	Generic drugs	Preventive Therapy Drugs: No charge. (Drugs that are subject to step therapy, brand penalty and prior authorization may not be covered at 100% by the plan) All others 20% **coinsurance**	Not Covered	Each prescription limited to a 30-day supply retail or a 90-day supply mail order. Specialty Drugs must be obtained through Caremark's Specialty Pharmacy. Specialty Drugs are limited to a 30 day supply.
	Brand name drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Physician/surgeon fees	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
If you need immediate medical attention	Emergency room services	Emergency visit 20% **coinsurance**; Non-emergency visit 50% **coinsurance**	Emergency visit 20% **coinsurance** (**preferred provider deductible** and **out-of-pocket limit** apply); Non-emergency visit 50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Emergency medical transportation	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Urgent care	20% **coinsurance**	20% **coinsurance** (**preferred provider deductible** and **out-of-pocket limit** apply)	**Non-preferred providers** limited to customary and reasonable amount.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	40% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
	Physician/surgeon fee	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Mental/Behavioral health inpatient services	20% **coinsurance**	40% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
	Substance use disorder outpatient services	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Substance use disorder inpatient services	20% **coinsurance**	40% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
If you are pregnant	Prenatal and postnatal care	No charge	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Delivery and all inpatient services	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
If you need help recovering or have other special health needs	Home health care	20% **coinsurance**	40% **coinsurance**	Limit one visit per day. $300 penalty applies if not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
	Rehabilitation services	20% **coinsurance**	40% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. Inpatient rehabilitation limited to 81 days while covered by this plan, combined with private duty nursing. **Non-preferred providers** limited to customary and reasonable amount.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs (continued)	Habilitation services	20% **coinsurance**	40% **coinsurance**	Physical, speech, occupational and behavioral therapy limited to a 35 visits per year (each). **Non-preferred providers** limited to customary and reasonable amount.
	Skilled nursing care	20% **coinsurance**	40% **coinsurance**	Home nursing requires pre-certification. Private duty nursing limited to 81 days while covered by this plan, combined with inpatient rehabilitation services. **Non-preferred providers** limited to customary and reasonable amount.
	Durable medical equipment	20% **coinsurance**	20% **coinsurance** (**preferred provider deductible** and **out-of-pocket limit** apply)	**Non-preferred providers** limited to customary and reasonable amount.
	Hospice service	20% **coinsurance**	40% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for eye exams.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental exams.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care (Adult and Children);	• Long-term care; • Non-emergency care when traveling outside the U.S.;	• Routine eye care (Adult and Children); and • Routine foot care.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture; • Bariatric surgery; • Chiropractic care;	• Hearing aids; • Infertility treatment;	• Private-duty nursing; and • Weight-loss programs.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-433-0318. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: CoreSource at 1-877-367-5690, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,730
- **Patient pays** $2,810

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$1,160
Limits or exclusions	$150
Total	**$2,810**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,070
- **Patient pays** $2,330

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$750
Limits or exclusions	$80
Total	**$2,330**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Trustmark Services Company: Qualified High Deductible Health Plan – Essential Option

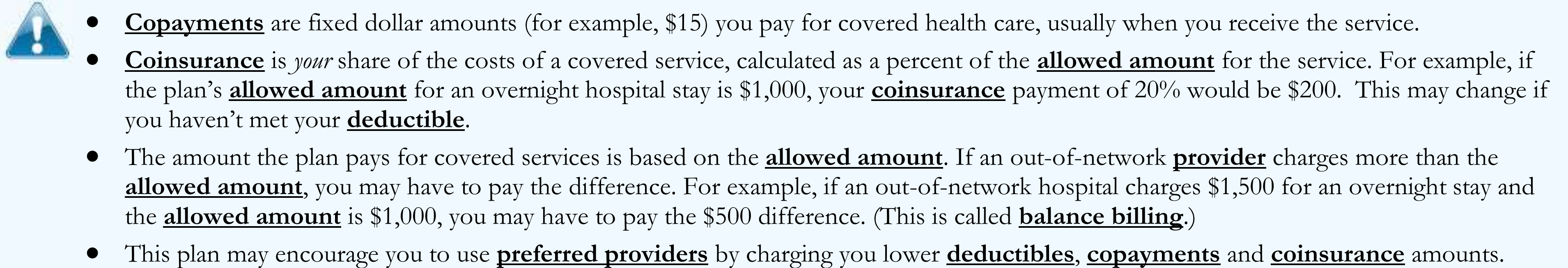
Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage Period: 01/01/2017 – 12/31/2017**

Coverage for: Employee, Employee + Spouse, Employee + Child(ren), Family | **Plan Type:** High Deductible

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document on the Virtual Water Cooler at https://my.trustmarkcompanies.com/wps/myportal/virtualwatercooler or by calling 1-877-367-5690. You may also access the Uniform Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** individual /**$5,000** aggregate family for **preferred providers** and **$5,000** individual /**$10,000** aggregate family for **non-preferred providers**. Doesn't apply to preventive care. **Copayments** and **coinsurance** do not apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. The **preferred provider** and **non-preferred provider deductibles** accumulate separately.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,500** individual **$11,000** aggregate family* for **preferred providers** and **$11,000** individual/ **$22,000** aggregate family for **non-preferred providers**. *No individual will have more than a $6,850 **preferred provider** Out of Pocket expense	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The **preferred provider** and **non-preferred provider out–of–pocket limits** accumulate separately.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties for failing to obtain required precertification and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.aetna.com or call **800-US-AETNA**; www.ipnmd.com or call **208-333-1513;** www.medcost.com or call **800-824-7406**; or www.preferredone.com or call **800-451-9597** for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.



- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Specialist visit	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Other practitioner office visit	20% **coinsurance**	40% **coinsurance**	Chiropractic care limited to 25 visits per year. **Non-preferred providers** limited to customary and reasonable amount.
	Preventive care/screening/ immunization	No charge	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com 1-866-644-7527.	Generic drugs	Preventive Therapy Drugs: No charge. (Drugs that are subject to step therapy, brand penalty and prior authorization may not be covered at 100% by the plan) All others 20% **coinsurance**	Not Covered	Each prescription limited to a 30-day supply retail or a 90-day supply mail order. Specialty Drugs must be obtained through Caremark's Specialty Pharmacy. Specialty Drugs are limited to a 30 day supply.
	Brand name drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Physician/surgeon fees	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
If you need immediate medical attention	Emergency room services	Emergency visit 20% **coinsurance**; Non-emergency visit 50% **coinsurance**	Emergency visit 20% **coinsurance** (**preferred provider deductible** and **out-of-pocket limit** apply); Non-emergency visit 50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Emergency medical transportation	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Urgent care	20% **coinsurance**	20% **coinsurance** (**preferred provider deductible** and **out-of-pocket limit** apply)	**Non-preferred providers** limited to customary and reasonable amount.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	40% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
	Physician/surgeon fee	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Mental/Behavioral health inpatient services	20% **coinsurance**	40% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
	Substance use disorder outpatient services	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Substance use disorder inpatient services	20% **coinsurance**	40% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
If you are pregnant	Prenatal and postnatal care	No charge	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Delivery and all inpatient services	20% **coinsurance**	40% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
If you need help recovering or have other special health needs	Home health care	20% **coinsurance**	40% **coinsurance**	Limit one visit per day. $300 penalty applies if not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
	Rehabilitation services	20% **coinsurance**	40% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. Inpatient rehabilitation limited to 81 days while covered by this plan, combined with private duty nursing. **Non-preferred providers** limited to customary and reasonable amount.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs (continued)	Habilitation services	20% **coinsurance**	40% **coinsurance**	Physical, speech, occupational and behavioral therapy limited to a 35 visits per year (each). **Non-preferred providers** limited to customary and reasonable amount.
	Skilled nursing care	20% **coinsurance**	40% **coinsurance**	Home nursing requires pre-certification. Private duty nursing limited to 81 days while covered by this plan, combined with inpatient rehabilitation services. **Non-preferred providers** limited to customary and reasonable amount.
	Durable medical equipment	20% **coinsurance**	20% **coinsurance** (**preferred provider deductible** and **out-of-pocket limit** apply)	**Non-preferred providers** limited to customary and reasonable amount.
	Hospice service	20% **coinsurance**	40% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for eye exams.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental exams.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care (Adult and Children);	• Long-term care; • Non-emergency care when traveling outside the U.S.;	• Routine eye care (Adult and Children); and • Routine foot care.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture; • Bariatric surgery; • Chiropractic care;	• Hearing aids; • Infertility treatment;	• Private-duty nursing; and • Weight-loss programs.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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Does this Coverage Provide Minimum Essential Coverage?

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,930
- **Patient pays** $3,610

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$960
Limits or exclusions	$150
Total	**$3,610**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,270
- **Patient pays** $3,130

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$550
Limits or exclusions	$80
Total	**$3,130**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Trustmark Services Company: Qualified High Deductible Health Plan–Balanced Option

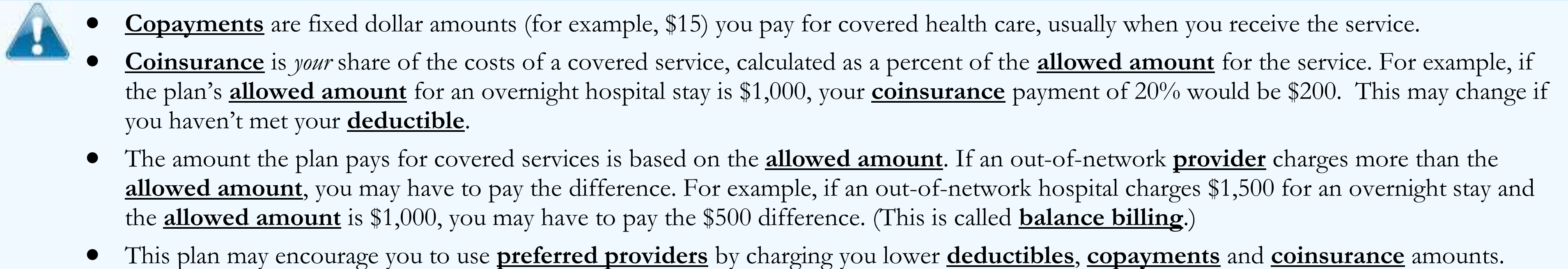
Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage Period: 01/01/2017 – 12/31/2017**

Coverage for: Employee, Employee + Spouse, Employee + Child(ren), Family | **Plan Type:** High Deductible

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document on the Virtual Water Cooler at https://my.trustmarkcompanies.com/wps/myportal/virtualwatercooler or by calling 1-877-367-5690. You may also access the Uniform Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,500** individual/**$9,000** aggregate family for **preferred providers** and **$6,350** individual/**$12,700** aggregate family for **non-preferred providers**. Doesn't apply to preventive care. **Copayments** and **coinsurance** do not apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. The **preferred provider** and **non-preferred provider deductibles** accumulate separately.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** individual/**$12,700** aggregate family* for **preferred providers** and no out of pocket maximum for **non-preferred providers**. *No individual will have more than a $6,850 **preferred provider** Out of Pocket expense	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The **preferred provider** and **non-preferred provider out–of–pocket limits** accumulate separately.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties for failing to obtain required precertification and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.aetna.com or call 800-US-AETNA; www.medcost.com or call 800-824-7406; or www.preferredone.com or call 800-451-9597 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.



- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% **coinsurance**	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Specialist visit	30% **coinsurance**	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Other practitioner office visit	30% **coinsurance**	50% **coinsurance**	Chiropractic care limited to 25 visits per year. **Non-preferred providers** limited to customary and reasonable amount.
	Preventive care/screening/ immunization	No charge	Not covered	[———————none———————]
If you have a test	Diagnostic test (x-ray, blood work)	30% **coinsurance**	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Imaging (CT/PET scans, MRIs)	30% **coinsurance**	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com 1-866-644-7527.	Generic drugs	Preventive Therapy Drugs: No charge. (Drugs that are subject to step therapy, brand penalty and prior authorization may not be covered at 100% by the plan) All others 30% **coinsurance**	Not Covered	Each prescription limited to a 30-day supply retail or a 90-day supply mail order. Specialty Drugs must be obtained through Caremark's Specialty Pharmacy. Specialty Drugs are limited to a 30 day supply.
	Brand name drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% **coinsurance**	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Physician/surgeon fees	30% **coinsurance**	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
If you need immediate medical attention	Emergency room services	Emergency visit 30% **coinsurance**; Non-emergency visit 50% **coinsurance**	Emergency visit 30% **coinsurance** (**preferred provider deductible** and **out-of-pocket limit** apply); Non-emergency visit 50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Emergency medical transportation	30% **coinsurance**	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Urgent care	30% **coinsurance**	30% **coinsurance** (**preferred provider deductible** and **out-of-pocket limit** apply)	**Non-preferred providers** limited to customary and reasonable amount.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	30% **coinsurance**	50% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
	Physician/surgeon fee	30% **coinsurance**	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% **coinsurance**	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Mental/Behavioral health inpatient services	30% **coinsurance**	50% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
	Substance use disorder outpatient services	30% **coinsurance**	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Substance use disorder inpatient services	30% **coinsurance**	50% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
If you are pregnant	Prenatal and postnatal care	No charge	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
	Delivery and all inpatient services	30% **coinsurance**	50% **coinsurance**	**Non-preferred providers** limited to customary and reasonable amount.
If you need help recovering or have other special health needs	Home health care	30% **coinsurance**	50% **coinsurance**	Limit one visit per day. $300 penalty applies if not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
	Rehabilitation services	30% **coinsurance**	50% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. Inpatient rehabilitation limited to 81 days while covered by this plan, combined with private duty nursing. **Non-preferred providers** limited to customary and reasonable amount.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs (continued)	Habilitation services	30% **coinsurance**	50% **coinsurance**	Physical, speech, occupational and behavioral therapy limited to a 35 visits per year (each). **Non-preferred providers** limited to customary and reasonable amount.
	Skilled nursing care	30% **coinsurance**	50% **coinsurance**	Home nursing requires pre-certification. Private duty nursing limited to 81 days while covered by this plan, combined with inpatient rehabilitation services. **Non-preferred providers** limited to customary and reasonable amount.
	Durable medical equipment	30% **coinsurance**	30% **coinsurance** (**preferred provider deductible** and **out-of-pocket limit** apply)	**Non-preferred providers** limited to customary and reasonable amount.
	Hospice service	30% **coinsurance**	50% **coinsurance**	$300 penalty applies to each inpatient admission that is not pre-certified. **Non-preferred providers** limited to customary and reasonable amount.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for eye exams.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental exams.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery	• Long-term care;	• Routine eye care (Adult and Children); and
• Dental care (Adult and Children);	• Non-emergency care when traveling outside the U.S.;	• Routine foot care.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture;	• Hearing aids;	• Private-duty nursing; and
• Bariatric surgery;	• Infertility treatment;	• Weight-loss programs.
• Chiropractic care;		

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-433-0318. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: CoreSource at 1-877-367-5690, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,060
- **Patient pays** $5,480

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,500
Copays	$0
Coinsurance	$830
Limits or exclusions	$150
Total	**$5,480**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $590
- **Patient pays** $4,810

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$4,500
Copays	$0
Coinsurance	$230
Limits or exclusions	$80
Total	**$4,810**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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