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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Medicare approved expenses.	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?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	None
	Specialist visit	Not covered	None
	Preventive care/screening/ immunization	No charge	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	None
	Imaging (CT/PET scans, MRIs)	No charge	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com.	Generic drugs	$5.00	Retail: 34-day to 90-day supply. Mail order: 90-day supply.
	Preferred brand drugs	$20.00	
	Non-preferred brand drugs	$40.00	
	Specialty drugs	Same as coverage levels listed above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	None
	Physician/surgeon fees	No charge	None
If you need immediate medical attention	Emergency room care	$100 copay	Copay waived if admitted or for accidental injury.
	Emergency medical transportation	No charge	None
	Urgent care	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	None
	Physician/surgeon fees	No charge	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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Excludes office visits.
	Inpatient services	No charge	
If you are pregnant	Office visits	Not covered	None
	Childbirth/delivery professional services	No charge	
	Childbirth/delivery facility services	No charge	
If you need help recovering or have other special health needs	Home health care	No charge	No charge for Medicare approved amount. Maximum: 100 visits per calendar year. Each visit by a nurse or therapist equals one visit. Each visit up to four hours equals one visit.
	Rehabilitation services	No charge	$1,900 for physical therapy and speech therapy services combined. $1,900 for occupational therapy services.
	Habilitation services	Not covered	None
	Skilled nursing care	No charge	100 days per benefit period.
	Durable medical equipment	No charge	None
	Hospice services	No charge	No charge for Medicare approved amount. Maximum: 30-days lifetime for inpatient. Maximum: $5,000 lifetime for outpatient.
If your child needs dental or eye care	Children's eye exam	Not covered	More information about vision coverage is available at www.e-nva.com.
	Children's glasses	Not covered	None
	Children's dental check-up	Not covered	More information about dental coverage is available at www.deltadental.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
- Chiropractic care (except for x-rays, adjustments/manipulations, and modalities when approved by Medicare)
- Cosmetic surgery
- Habilitation services
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-Medicare approved services
- Office visits, other than those required by law
- Routine eye care (Adult)
- Routine foot care (unless approved by Medicare
- Weight loss programs

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

- Bariatric surgery
- Private-duty nursing
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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 the Retirement Unit of the Human Resources Department at 1-248-858-7592..

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 1-248-858-7592.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-248-858-7592.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-248-858-7592.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-248-858-7592.

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** **$0**
- **Specialist** **Not Covered**
- **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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
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** **Not Covered**
- **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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,000
The total Joe would pay is	**$1,600**

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

- **The plan's overall deductible** **$0**
- **Specialist** **Not Covered**
- **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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$300
The total Mia would pay is	**$400**

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