Trustmark

Small Business Benefits
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ADDRESS SERVICE REQUESTED

12/03/24

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Group No.: SM90960C

Enclosed is your Summary of Benefits and Coverage (SBC) describing your medical coverage administered by Star Marketing and Administration, Inc. This SBC has been delivered to you to comply with the Patient Protection and Affordable Care Act.

The SBC is a standardized summary of health plan coverage that allows you to easily identify and compare the benefits available. It summarizes the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

If you have any questions or concerns, please call 1-800-522-1246, ext. 26300.

Enclosure

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, visit TrustmarkSB.com or call 1-800-522-1246, ext. 26300. 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 1-800-522-1246, ext. 26300 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network: $2,000/individual $4,000/family For out-of-network: $5,000/individual $10,000/family Per Calendar Year	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 are covered before you meet your deductible: Preventive Care, Prescription Drugs, Primary Care Services, Urgent Care Visits, Emergency Room Visits, Speech, Occupation and Physical Therapy Visits, Diagnostic Tests, Imaging Services	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?	Yes, $250/individual for outpatient prescription drug expenses. There are no other deductibles.	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

Important Questions	Answers	Why This Matters:
What is the out-of-pocket limit for this plan?	For in-network: $5,000/individual $10,000/family For out-of-network: $15,000/individual $30,000/family Per Calendar Year	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?	Pre-certification penalties, premiums, balanced-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 TrustmarkSB.com or call 1-800-522-1246, ext. 26300 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.

		What You Will Pay		
Common Medical Event	**Services You May Need**	**In-Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
	Primary care visit to treat an injury or illness	$30 copay/office visit and 50% coinsurance for other outpatient services.	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	Specialist visit	$30 copay/office visit and 50% coinsurance for other outpatient services.	50% coinsurance	services you need are preventive. Then check what your plan will pay for. General medical and dermatology telemedicine services via Teladoc® are available for $0 per consult.
	Preventive care/screening/ immunization	No charge for covered services.	50% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance, deductible does not apply	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$300 copay/procedure	50% coinsurance	$300 penalty for failure to precertify.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	$20 copay/prescription (retail), $40 copay/prescription (mail order)	$20 copay/prescription (retail), $40 copay/prescription (mail order)	Covers up to a 30-day supply for a retail prescription; up to a 90 day supply for a mail order prescription.
More information about prescription drug coverage is available at TrustmarkSB.com	Preferred brand drugs (Tier 2)	$65 copay/prescription (retail), $160 copay/prescription (mail order)	$65 copay/prescription (retail), $160 copay/prescription (mail order)	Covers up to a 30-day supply for a retail prescription; up to a 90 day supply for a mail order prescription. Separate $250 deductible/person.
	Non-preferred brand drugs (Tier 3)	$95 copay/prescription (retail), $285 copay/prescription (mail order)	$95 copay/prescription (retail), $285 copay/prescription (mail order)	Covers up to a 30-day supply for a retail prescription; up to a 90 day supply for a mail order prescription. Separate $250 deductible/person.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs (Tier 4)	$0^ ^PrudentRx eligible medicines: 30% after prescription deductible is met; $0 if enrolled in PrudentRx. Non-eligible medicines: $200copay/prescription (retail) after prescription deductible is met.	Not covered	Covers up to a 30-day supply. For members enrolled in PrudentRx, eligible specialty drugs have $0 cost sharing. If you opt out or fail to enroll in PrudentRx, you are responsible for the 30% coinsurance for PrudentRx eligible drugs. Payments for these medications will not count toward your deductible or out-of-pocket for non-EHB medications. See plan document for more details. Separate $250 deductible/person.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$2,000 access fee then 50% coinsurance	$2,000 access fee then 50% coinsurance	None
	Physician/surgeon fees	50% coinsurance	50% coinsurance	
	Emergency room care	$500 copay/visit	$500 copay/visit	None
If you need immediate medical attention	Emergency medical transportation	50% coinsurance	50% coinsurance	
	Urgent care	$100 copay/visit	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$2,000 access fee then 50% coinsurance	$2,000 access fee then 50% coinsurance	$300 penalty for failure to precertify.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	$300 penalty for failure to precertify.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/visit for primary care/specialist visit, $100/visit for urgent care, $500 copay/visit for emergency room services, $2,000 Access Fee then 50% coinsurance for outpatient surgery, or 50% coinsurance for other outpatient services	$500 copay/visit for emergency room services, $2,000 Access Fee then 50% coinsurance for outpatient surgery, or 50% coinsurance for other outpatient services	Mental health telemedicine services via Teladoc® are available for $0 per consult.
	Inpatient services	$2,000 Access Fee then 50% coinsurance for inpatient hospitalization or 50% coinsurance for other inpatient services	$2,000 Access Fee then 50% coinsurance for inpatient hospitalization or 50% coinsurance for other inpatient services	$300 penalty for failure to precertify.
	Office visits	0% coinsurance routine prenatal visits, 50% coinsurance other services	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you are pregnant	Childbirth/delivery professional services	50% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, 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	50% coinsurance	50% coinsurance	$300 penalty for failure to precertify.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Home health care	50% coinsurance	50% coinsurance	100 days/year. $300 penalty for failure to precertify.
If you need help recovering or have other special health needs	Rehabilitation services	$30 copay/visit for Speech, Occupational and Physical therapy, 50% coinsurance for other services.	50% coinsurance	60 visits/year. Inpatient rehabilitation: $300 penalty for failure to precertify.
	Habilitation services	$30 copay/visit for Speech, Occupational and Physical therapy, 50% coinsurance for other services.	50% coinsurance	60 visits/year. Inpatient habilitation: $300 penalty for failure to precertify.
	Skilled nursing care	50% coinsurance	50% coinsurance	81 days/year. $300 penalty for failure to precertify.
	Durable medical equipment	50% coinsurance	50% coinsurance	None
	Hospice services	50% coinsurance	50% coinsurance	6 months while covered under this plan. $300 penalty for failure to precertify.
If your child needs dental or eye care	Children's eye exam	Routine vision screening: No charge. Other services, including routine eye exam: Not covered.	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- 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.)

- Acupuncture (if prescribed for rehabilitation purposes), 12 visits per plan year
- Chiropractic care, 20 visits per plan year
- 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. 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 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: 1-800-522-1246, ext. 26300 or the U.S. 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 1-800-522-1246, ext. 26300

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-522-1246, ext. 26300

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-522-1246, ext. 26300

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-522-1246, ext. 26300

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

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	**$2,000**
Specialist copay	**$30**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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*	$4,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$5,050**

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

The plan's overall deductible	**$2,000**
Specialist copay	**$30**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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*	$300
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$500
The total Joe would pay is	**$2,300**

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

The plan's overall deductible	**$2,000**
Specialist copay	**$30**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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*	$1,200
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

***** This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.