**Cherokee County POS Plan Employee Benefit Plan (Anthem BCBS Plan)** **Coverage for: Single + Family** | **Plan Type:** POS

**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, contact 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 www.cciio.cms.gov or call 1-877-267-2323 to request a copy. Questions: Call 1-877-279-5285 or visit us at www.myTrustmarkBenefits.com for more information, including a copy of your plan's plan document and summary plan description.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **Preferred Providers**: **$750** person/**$2,250** family **Nonpreferred Providers**: **$6,000** person/**$18,000** family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes - true medical emergency services, ambulance services, hospice care, **nonpreferred provider** preventive care for children under age 6, and the following **preferred provider** services: office services, urgent care centers, therapy services; preventive care and the prescription drug program. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **Preferred Providers**: **$2,000** person/**$6,000** family **Nonpreferred Providers**: **$9,000** person/**$27,000** family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, penalties for failure to pre-certify services, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See **www.anthem.com** or call **1-800-810-2583** for a list of participating 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).<br>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 |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred 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 | $25 copay/visit; (deductible does not apply) | 40% coinsurance | None |
| | Specialist visit | $30 copay/visit; (deductible does not apply) | 40% coinsurance | None |
| | Preventive care/screening/ immunization | No charge (deductible does not apply) | Birth thru age 5: 40% coinsurance (deductible does not apply); Age 6 and over: 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) | Office $25/$30 copay/visit; (deductible does not apply); Other 20% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.us-rxcare.com or call 877-200-5533. | Generic drugs | $10 copay retail and $25 copay mail order/ prescription | Not covered | Deductible does not apply.<br>Covers up to a 30-day supply (retail prescription and specialty drugs); 90 day supply (mail order prescription).<br>Prescription drug copays don't apply to preventive drugs. |
| | Preferred brand drugs | $35 copay retail and $50 copay mail order/ prescription | Not covered | |
| | Non-preferred brand drugs | $80 copay retail and $50 copay mail order/ prescription | Not covered | |
| | Specialty drugs | 20% coinsurance up to maximum of $200/ prescription | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 0% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $250 copay (deductible does not apply) | Preferred provider benefit applies | Copay waived if admitted. |
| | Emergency medical transportation | No charge (deductible does not apply) | Preferred provider benefit applies | Must be medically necessary. |
| | Urgent care | $30 copay (deductible does not apply) | 40% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 copay, then 20% coinsurance | 40% coinsurance | Pre-certification is required. |
| | Physician/surgeon fees | 0% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay (deductible does not apply) | 40% coinsurance | None |
| | Inpatient services | Facility: $500 copay, then 20% coinsurance; Professional: 0% coinsurance | 40% coinsurance | Pre-certification is required. |
| **If you are pregnant** | Office visits | No charge (deductible does not apply) | 40% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (*i.e.*, ultrasound.) |
| | Childbirth/delivery professional services | 0% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | $500 copay, then 20% coinsurance | 40% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance | 40% coinsurance | Coverage is limited to 120 visits/calendar year. Pre-certification is required. |
| | Rehabilitation services | Respiratory, Radiation and Chemotherapy: No charge (deductible does not apply); Other therapies: $25 copay (deductible does not apply) | 40% coinsurance | Coverage is limited to 20 visits/calendar year for physical & occupational therapy, combined; 20 visits/calendar year for speech therapy and 30 visits/calendar year for respiratory therapy. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | None |
| | Skilled nursing care | 0% coinsurance | 40% coinsurance | Coverage is limited to 30 days/calendar year. Pre-certification is required. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | None |
| | Hospice services | No charge (deductible does not apply) | No charge (deductible does not apply) | Pre-certification is required for inpatient hospice care. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | No coverage for eye exams under medical. |
| | Children's glasses | Not covered | Not covered | No coverage for glasses under medical. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-ups under medical. |

## 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;
- Bariatric surgery;
- Chiropractic care;
- Cosmetic surgery;
- Dental care;
- Infertility treatment;
- Long-term care;
- Private-duty nursing;
- Routine eye care;
- Routine foot care, and
- Weight-loss programs.

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

- Hearing aids, for children up to age 18, limited to $3,000 per ear every 48 months; and
- Non-emergency care when traveling outside the U.S.

**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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Contact Trustmark Health Benefits, Inc. at 1-877-279-5285 or visit us at www.myTrustmarkBenefits.com.

**Does this plan provide Minimum Essential Coverage?** **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.

*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 | $750 |
| Specialist copay | $30 |
| Hospital (facility) copay/coinsurance | $500/20% |
| Other coinsurance | 20% |

**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** | **$12,840** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $750 |
| Copayments | $1,214 |
| Coinsurance | $36 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,060** |

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

| | |
|---|---|
| The plan's overall deductible | $750 |
| Specialist copay | $30 |
| Hospital (facility) copay/coinsurance | $500/20% |
| Other coinsurance | 20% |

**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** | **$7,460** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $750 |
| Copayments | $923 |
| Coinsurance | $327 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$2,055** |

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

| | |
|---|---|
| The plan's overall deductible | $750 |
| Specialist copay | $30 |
| Hospital (facility) copay/coinsurance | $500/20% |
| Other coinsurance | 20% |

**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** | **$2,010** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $83 |
| Copayments | $940 |
| Coinsurance | $21 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,044** |

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