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, see www.TrustmarkBenefits.com and/or call 1-877-498-8937. 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 1-877-498-8937 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers **$2,000** individual / **$4,000** family For non-network providers **$6,000** individual / **$12,000** family (Please note: prescription drugs apply)	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	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?	For network providers **$3,000** individual / **$6,000** family For non-network providers **$12,000** individual / **$24,000** 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Pre-certification penalties, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-311-3842 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).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	30% coinsurance	None.
	Specialist visit	0% coinsurance	30% coinsurance	None.
	Preventive care/screening/ immunization	No Charge	30% 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. Out of Network Routine Well Child Exams and Immunizations covered at no charge.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com.	Generic drugs	$10 copay for retail $20 copay for mail order	30% of submitted cost; after applicable copay for retail Not applicable for mail order	Retail limited to a 30 day supply Mail order limited to 31-90 day supply
	Preferred brand drugs	$20 copay for retail $40 copay for mail order	30% of submitted cost; after applicable copay for retail Not applicable for mail order	
	Non-preferred brand drugs	$35 copay for retail $70 copay for mail order	30% of submitted cost; after applicable copay for retail Not applicable for mail order	
	Specialty drugs	Same as Retail copay	Not Covered	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	None.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None.
If you need immediate medical attention	Emergency room care	0% coinsurance		Copay waived if admitted. Non-Emergency care in an emergency room is not covered.
	Emergency medical transportation	0% coinsurance		Non-emergency use of ambulance not covered.
	Urgent care	0% coinsurance	30% coinsurance	Non-urgent use of urgent care is not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Precertification is required. $300 penalty for failure to pre-certify.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	30% coinsurance	None.
	Inpatient services	0% coinsurance	30% coinsurance	Precertification is required. $300 penalty for failure to pre-certify.
If you are pregnant	Office visits	0% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	None.
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	Precertification is required. $300 penalty for failure to pre-certify.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	Limited to 120 visits per benefit period. Precertification is required. $300 penalty for failure to pre-certify.
	Rehabilitation services	0% coinsurance	30% coinsurance	Limited to 60 visits per benefit period for speech, occupational and physical therapy. Unlimited for early intervention services from birth to age 3.
	Habilitation services	0% coinsurance	30% coinsurance	None.
	Skilled nursing care	0% coinsurance	30% coinsurance	Limited to 120 visits per benefit period. Precertification is required. $300 penalty for failure to pre-certify.
	Durable medical equipment	50% coinsurance	50% coinsurance	None.
	Hospice services	0% coinsurance	30% coinsurance	Precertification is required for Inpatient. $300 penalty for failure to pre-certify.
If your child needs dental or eye care	Children's eye exam	No Charge	30% coinsurance	Routine Eye Exams Covered 100%; deductible waived for all members. 1 routine exam per 12 months covered under preventive care
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	None.

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.)

- Cosmetic surgery
- Dental care (Adult)
- 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
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2000 per 36 months)
- Infertility treatment
- Private-duty nursing (Limited to 70 eight hour shifts per year.)

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: The Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-498-8937.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-498-8937.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-498-8937.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-498-8937.

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.TrustmarkBenefits.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	$2000
Specialist *coinsurance*	0%
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2000
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2100**

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

The plan's overall deductible	$2000
Specialist *coinsurance*	0%
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2000
Copayments	$570
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2625**

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

The plan's overall deductible	$2000
Specialist *coinsurance*	0%
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1925**

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