




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](http://www.myTrustmarkBenefits.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 <https://www.healthcare.gov/sbc-glossary> or call 1-877-498-8937 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">network providers</a> <b>\$100</b> individual / <b>\$200</b> family For <a href="#">non-network providers</a> <b>\$500</b> individual / <b>\$1,000</b> family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Emergency care, plus In-Network office visits, prescription drugs and <a href="#">Preventive care</a> , are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> <b>\$1,500</b> individual / <b>\$3,000</b> family For <a href="#">non-network providers</a> <b>\$1,500</b> individual / <b>\$3,000</b> family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Pre-certification penalties, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.cigna.com">www.cigna.com</a> or call 1-800-311-3842 for a list of <a href="#">network providers</a>	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such

Important Questions	Answers	Why This Matters:
		as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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)	Non-Preferred Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Out of Network Routine Well Child Exams and Immunizations covered at no charge.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> .	Generic drugs	\$10 <a href="#">copay</a> for retail \$20 <a href="#">copay</a> for mail order <a href="#">Deductible</a> does not apply	20% of submitted cost; after applicable <a href="#">copay</a> for retail Not applicable for mail order	Retail limited to a 30 day supply Mail order limited to 31-90 day supply <a href="#">Copays</a> do not apply to generic contraceptives. Please refer to <a href="http://www.hrsa.gov/womensguidelines.com">www.hrsa.gov/womensguidelines.com</a>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Preferred brand drugs	\$20 <a href="#">copay</a> for retail \$40 <a href="#">copay</a> for mail order <a href="#">Deductible</a> does not apply	20% of submitted cost; after applicable <a href="#">copay</a> for retail Not applicable for mail order	
	Non-preferred brand drugs	\$35 <a href="#">copay</a> for retail \$70 <a href="#">copay</a> for mail order <a href="#">Deductible</a> does not apply	20% of submitted cost; after applicable <a href="#">copay</a> for retail Not applicable for mail order	
	<a href="#">Specialty drugs</a>	Same as retail <a href="#">copay</a>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$75 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply	Preferred provider benefit applies.	<a href="#">Copay</a> waived if admitted. Non-Emergency care in an emergency room is not covered..
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	Preferred provider benefit applies.	Non-emergency use of ambulance not covered.
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	Non-urgent use of urgent care is not covered
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. \$300 penalty for failure to pre-certify.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a> per office visit <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	Inpatient services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. \$300 penalty for failure to pre-certify.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.myTrustmarkBenefits.com](http://www.myTrustmarkBenefits.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
<b>If you are pregnant</b>	Office visits	\$25 <a href="#">copay</a> per office visit <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . No charge for initial visit. Depending on the type of services, a <a href="#">copay</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	20% <a href="#">coinsurance</a>	Limited to 120 visits per benefit period. <a href="#">Precertification</a> is required. \$300 penalty for failure to pre-certify.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Limited to 60 visits per benefit period for speech, occupational and physical therapy. Unlimited for early intervention services from birth to age 3.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Limited to 120 visits per benefit period. <a href="#">Precertification</a> is required. \$300 penalty for failure to pre-certify.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required for Inpatient. \$300 penalty for failure to pre-certify.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	20% <a href="#">coinsurance</a>	Routine Eye Exams Covered 100%; deductible waived for all members. Limited to 1 routine exam per benefit period.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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## 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 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.)
- Routine eye care

**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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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 1-877-498-8937

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, kwijigo holne' 1-877-498-8937.

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

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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](#) \$100
- [Specialist copay](#) \$25
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$170</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copay](#) \$25
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$720</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copay](#) \$25
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$400</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.