




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?	For network providers \$1,500 individual / \$3,000 family For non-network providers \$3,000 individual / \$6,000 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. Network preventive care, well child care or women’s preventive care.	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?	Medical: For network providers \$4,100 individual / \$8,200 family; For non-network providers - Not applicable Prescription Network and Non-network \$2,500 individual/ \$5,000 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 , balance-billing charges, plan penalties and health care this plan doesn’t cover. The prescription drug copays are not included in the Medical out-of-pocket and the Medical deductible	Even though you pay these expenses, they don’t count toward the out-of-pocket limit .

Important Questions	Answers	Why This Matters:
	and copays are not included in the Prescription out-of-pocket limit.	
Will you pay less if you use a network provider ?	Yes. See www.mycigna.com or call 1-800-785-3602 for a list of 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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay /visit Deductible does not apply	20% coinsurance	None
	Specialist visit	\$25 copay /visit Deductible does not apply	20% coinsurance	None
	Preventive care/screening/immunization	No charge	Not covered except for Mammogram and Colonoscopy 20% 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)	0% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about	Generic drugs	\$10 copay /prescription (retail) \$20 copay /prescription (mail order) Deductible does not apply	\$10 copay /prescription (retail) \$20 copay /prescription (mail order) Deductible does not apply	Covers up to a 30 day supply (retail) Covers up to a 90 day supply (mail order)

* 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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
prescription drug coverage is available at www.pharmavail.com .	Preferred brand drugs	\$50 copay /prescription (retail) \$100 copay /prescription (mail order) Deductible does not apply	\$50 copay /prescription (retail) \$100 copay /prescription (mail order) Deductible does not apply	Copays do not apply to generic contraceptives. Please refer to www.hrsa.gov/womensguidelines.com
	Non-preferred brand drugs	\$100 copay /prescription (retail) \$200 copay /prescription (mail order) Deductible does not apply	\$100 copay /prescription (retail) \$200 copay /prescription (mail order) Deductible does not apply	
	Specialty drugs	\$100 copay /prescription (retail) \$200 copay /prescription (mail order) Deductible does not apply	\$100 copay /prescription (retail) \$200 copay /prescription (mail order) Deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	\$150 copay /visit. Deductible does not apply	Preferred provider benefit applies.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	Preferred provider benefit applies.	None
	Urgent care	\$40 copay /visit Deductible does not apply	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Pre-certification is required.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay per office visit Deductible does not apply; 0% coinsurance	20% coinsurance	None
	Inpatient services	0% coinsurance	20% coinsurance	Pre-certification is required.

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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 are pregnant	Office visits	\$25 copay per office visit Deductible does not apply	20% coinsurance	Cost sharing does not apply for preventive services . No charge for initial visit. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Pre-certification is required.
	Rehabilitation services	0% coinsurance	20% coinsurance	Limited to 60 visits in a calendar year for a combination of all outpatient occupational, physical, and speech therapy
	Habilitation services	0% coinsurance	20% coinsurance	Limited to 60 visits in a calendar year for a combination of all outpatient occupational, physical, and speech therapy
	Skilled nursing care	0% coinsurance	20% coinsurance	Limited to 120 days in a calendar year.
	Durable medical equipment	0% coinsurance	20% coinsurance	None
	Hospice services	0% coinsurance	20% coinsurance	Respite care up to five days in each 6 month period.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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 .)		
<ul style="list-style-type: none"> • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Hearing Aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Most coverage provided outside the U.S. • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private Duty Nursing • Routine eye care (Adult) • Routine Foot Care • Weight Loss programs

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

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 and /or surgery)
- Chiropractic care (limited to 24 visits in a calendar 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: Department of Labor's Employee Benefits Security Administration at 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 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.

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 1-833-565-0549.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-565-0549.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-833-565-0549.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-565-0549.

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](#) \$1500
- [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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1500
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1570

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1500
- [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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$1000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1920

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1500
- [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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1500
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1700

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