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, **call Jefferson Local Schools at 1-614-879-7654**. 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.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-new.pdf or **call 1-614-879-7654** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO Providers – **$250** individual / **$500** family Non-PPO Providers – **$400** individual / **$800** 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. In-network preventive care services and in-network routine prenatal care are 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?	**Medical:** PPO Providers – **$1,050** individual / **$1,900** family Non-PPO Providers - **$1,500** individual / **$2,400** family **Prescriptions:** **$5,550** individual / **$11,300** 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-billed 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. Cigna PPO applies inside and outside of Ohio. See www.mycigna.com 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). 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
		PPO Provider (You will pay the least)	Non-PPO 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	15% coinsurance	30% coinsurance	----------none----------
	Specialist visit	15% coinsurance	30% coinsurance	----------none----------
	Preventive care/screening/ immunization	No charge	Not covered	As specified under the Patient Protection and Affordable Care Act. 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)	15% coinsurance	30% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from Rx Benefits at 1-800-334-8134 or www.rxbenefits.com There is a separate out-of-pocket limit for drugs: **$5,550** individual / **$11,300** family	Generic drugs (Retail pharmacy)	$10 copay per prescription	Claim form must be filed for out-of-network pharmacies	For a 34 day supply at retail.
	Formulary drugs (Retail pharmacy)	$25 copay per prescription	Claim form must be filed for out-of-network pharmacies	For a 34 day supply at retail.
	Non-Formulary drugs (Retail pharmacy)	$40 copay per prescription	Claim form must be filed for out-of-network pharmacies	For a 34 day supply at retail.
	Generic drugs (Retail or Mail Order)	$15 copay per prescription	Mail order through CVS/Caremark only	For a three month supply (retail or mail order).
	Formulary drugs (Retail or Mail Order)	$37.50 copay per prescription	Mail order through CVS/Caremark only	For a three month supply (retail or mail order).
	Non-Formulary drugs (Retail or Mail Order)	$60 copay per prescription	Mail order through CVS/Caremark only	For a three month supply (retail or mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance	----------none----------
	Physician/surgeon fees	15% coinsurance	30% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	$75 copay per visit	$75 copay per visit	Copay amount is waived if admitted. One visit allowed without copay per 12-month period beginning each January 1st.
	Emergency medical transportation	15% coinsurance	30% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
	Urgent care	15% coinsurance	30% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	30% coinsurance	----------none----------
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Concurring second surgical opinion required for specific tissue and organ transplants.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	30% coinsurance	----------none----------
	Inpatient services	15% coinsurance	30% coinsurance	----------none----------
If you are pregnant	Office visits	Routine prenatal care: No charge All other services: 15% coinsurance	30% coinsurance	Routine prenatal care covered at no charge as specified by the Patient Protection and Affordable Care Act.
	Childbirth/delivery professional services	15% coinsurance	30% coinsurance	----------none----------
	Childbirth/delivery facility services	15% coinsurance	30% coinsurance	----------none----------
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance	Limited to 120 visits per calendar year.
	Rehabilitation services	15% coinsurance	30% coinsurance	----------none----------
	Habilitation services	15% coinsurance	30% coinsurance	See summary plan description booklet for specific exclusions.
	Skilled nursing care	15% coinsurance	30% coinsurance	Limited to 120 days per calendar year.
	Durable medical equipment	15% coinsurance	30% coinsurance	----------none----------
	Hospice services	15% coinsurance	30% coinsurance	Limited to 180 days lifetime maximum.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	As specified under the Patient Protection and Affordable Care Act. Please refer to the Vision Plan for additional benefits not related to ACA guidelines.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	No charge	Not covered	As specified under the Patient Protection and Affordable Care Act. Please refer to the Dental Plan for additional benefits not related to ACA guidelines.

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) – See dental plan for coverage
- Habilitation services (See summary plan description booklet for specific exclusions)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult) – See vision plan for coverage
- Routine foot care

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

- Acupuncture (performed by a physician only)
- Bariatric surgery (Covered only with a diagnosis of morbid obesity.)
- Chiropractic care (Limit 25 visits per calendar year.)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs (Covered only with a diagnosis of morbid obesity.)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-614-879-7654. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services 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 Jefferson Local Schools at 1-614-879-7654. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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.

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	$250
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$250
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,110**

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

The plan's overall deductible	$250
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$250
Copayments	$460
Coinsurance	$250
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,015**

These numbers assume diabetic medications are purchased through the mail order service.

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

The plan's overall deductible	$250
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$250
Copayments	$75
Coinsurance	$325
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

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