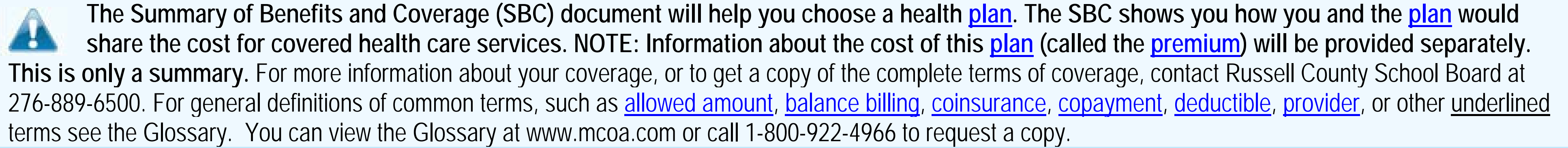
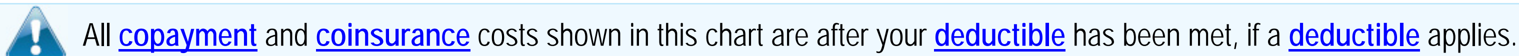


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Russell County School Board at 276-889-6500. 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.mcoa.com or call 1-800-922-4966 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers:$7,350 individual / $14,700 family. Non-network providers $75,000 individual / $150,000 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. Preventive care services 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?	For network providers $7,350 individual / $14,700 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?	Cost containment penalties, Copayments for certain services, 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.mycigna.com 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). 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 chose without a referral.



Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/office visit	80% coinsurance	In network deductible waived.
	Specialist visit	$20 copay/visit	80% coinsurance	In network deductible waived.
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	80% coinsurance	Coinsurance waived on for all Labcard participating providers.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	80% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com	Generic drugs (Tier 1)	$5 copay/prescription (retail) $12.50 copay / prescription (mail order)	Not Covered	Tier 1, 2 and 3 covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail) $75 copay / prescription (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	The greater of $50 or 20% copay (up to $200) /prescription (retail) The greater of $125 or 20% copay (up to $400) /prescription (mail order)	Not Covered	
	Specialty drugs (Tier 4)	The greater of $85 or 20% copay (up to $300) /prescription (retail). supply (mail order)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	80% coinsurance	None
	Physician/surgeon fees	50% coinsurance	80% coinsurance	Applies when performed in other than a physician's office.
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	None
	Emergency medical	50% coinsurance	80% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	transportation			
	Urgent care	$25 copay/visit	80% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	80% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced on the total cost of the service.
	Physician/surgeon fees	50% coinsurance	80% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit	80% coinsurance	Outpatient -In network deductible waived. Preauthorization is required for inpatient stays. If you don't get preauthorization, benefits could be reduced on the total cost of the service.
	Inpatient services	50% coinsurance	80% coinsurance	
If you are pregnant	Office visits	$20 copay/visit	80% coinsurance	Office visits – In network deductible waived
	Childbirth/delivery professional services	50% coinsurance	80% coinsurance	
	Childbirth/delivery facility services	50% coinsurance	80% coinsurance	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	80% coinsurance	Limited to 30 visits per Calendar Year. In and out of network combined.
	Rehabilitation services	50% coinsurance	80% coinsurance	Limited to 60 visits per Calendar Year combined for occupational, speech, cardiac, pulmonary and physical therapies. In and out of network combined
	Habilitation services	50% coinsurance	80% coinsurance	
	Skilled nursing care	50% coinsurance	80% coinsurance	Limited to 60 days per Calendar Year. In and out of network combined.
	Durable medical equipment	50% coinsurance	80% coinsurance	None
	Hospice services	50% coinsurance	80% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$15 copay/visit	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.)		
• Acupuncture • Cosmetic Surgery • Dental Care • Infertility Treatment	• Long Term Care • Hearing Aids • 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.)		
• Bariatric Surgery • Chiropractic Care	• Private Duty Nursing	Routine eye care (Adult)

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 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 90 Degree Benefits Inc., at 1-800-922-4966 or contact the plan at 276-889-6500. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additional help may also be found in your state by visiting: www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants

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 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 1-800-922-4966.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-922-4966.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-922-4966.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-922-4966

———————————————*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 $7,350
- Specialist copayment $20
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

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	$7,200
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,410**

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

- The plan's overall deductible $7,350
- Specialist copayment $20
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

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*	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$800
The total Joe would pay is	**$1,400**

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

- The plan's overall deductible $7,350
- Specialist copayment $20
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

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*	$2,430
Copayments	$70
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,430**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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