FLOYD COUNTY PUBLIC SCHOOLS
140 Harris Hart Road NE
Floyd, VA 24091
Telephone: (540) 745-9400 FAX: (540) 745-9496

September 1, 2022

ACKNOWLEDGEMENT OF RECEIPT
FOR NOTICE OF EXCHANGES (or MARKETPLACES) AND SUBSIDIES

As required by the Affordable Care Act (AFA), this notice is being provided to you as part of Health Care Reform. Please find attached the Notice of New Health Insurance Marketplace Coverage Options and Health Insurance Coverage. The notice contains important information regarding marketplace exchanges and premium subsidies that may be available to you. Also attached is the Summary of Benefits and Coverage (SBC) Notice for health insurance options available through the Floyd County School Division to eligible employees. Please read the attached information carefully. Additional information may be found at: https://www.healthcare.gov/.

Please acknowledge receipt of the following documents and return this form to the Floyd County School Board Office:

- Notice of New Health Insurance Marketplace Coverage
- Summary of Benefits and Coverage (SBC)
- Medicare Creditable Coverage Notice

_____	_____	_____
Print Name	Employee's Signature	Date

FLOYD COUNTY PUBLIC SCHOOLS
140 Harris Hart Road NE
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MEMORANDUM TO: All Employees including full-time, part-time, Substitutes, and any individuals eligible to work in the Floyd County School Division

FROM: Janet C. Harris, Director of Personnel Services

THROUGH: Dr. John F. Wheeler, Division Superintendent

RE: Notice of Health Insurance Marketplace/Exchange

DATE: September 1, 2022

This notice is being provided to you as required by the Affordable Care Act (AFA). In 2014, the Health Care Reform law created a new type of online marketplace for purchasing health insurance coverage. This marketplace is referred to as a Health Insurance Marketplace, or an Exchange.

Effective October 2013, you have been able to find and compare health insurance plans through the Marketplace. If you decide to purchase coverage through the Marketplace, you may be eligible for a federal subsidy that lowers your monthly premiums or reduces your cost sharing. However, to receive these federal savings, you cannot be eligible for "affordable" health plan coverage that provides "minimum value" benefits through your employer.

Because Floyd County Public Schools currently makes available insurance coverage that is "affordable" and provides "minimum value" to full-time employees as defined by school division policy, the availability of coverage through the Marketplace generally will not affect these employees. However, for all other part-time employees who are currently not eligible for health insurance through the school division, the Marketplace will provide you with options to find and purchase affordable health insurance.

Please find attached the Notice of New Health Insurance Marketplace Coverage Options and Health Insurance Coverage. Also enclosed is a Summary of Benefits and Coverage (SBC) Notice for health insurance options that is available through the school division to eligible employees effective October 1, 2022. Information on the school division's health plan coverage for 2023 will be provided at its next open enrollment period prior to October 1, 2023. If you have questions regarding the school division's health plan coverage, please contact the Payroll/Benefits Office at 540-745-9400 or email at: harrisj@floyd.k12.va.us. More information on the Health Care Reform law and the Marketplaces is available at www.healthcare.gov.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact FLOYD COUNTY PUBLIC SCHOOLS PAYROLL/BENEFITS OFFICE.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
FLOYD COUNTY PUBLIC SCHOOLS	54-6001281
5. Employer address 140 HARRIS HART ROAD NE	6. Employer phone number 540-745-9400

7. City	8. State	9. ZIP code
FLOYD	VA	24091

10. Who can we contact about employee health coverage at this job?	
FLOYD COUNTY PUBLIC SCHOOLS PAYROLL/BENEFITS OFFICE	
11. Phone number (if different from above) 540-745-9400	12. Email address HARRISJ@FLOYD.K12.VA.US

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

FULL-TIME EMPLOYEES AS DEFINED BY FLOYD COUNTY SCHOOL BOARD POLICY; SCHOOL BOARD POLICY MANUAL MAY BE ACCESSED AT WWW.FLOYD.K12.VA.US

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse and dependent children (until end of month in which they reach age 26) of full-time employees as defined by policy.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $16.00
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Floyd County Public Schools $1,500 Deductible PPO Group Health Plan

Coverage Period: 10/01/2022-9/30/2023

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.bpatpa.com** or by calling **833-440-7628**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** individual / **$3,000** family for Network **$3,000** individual / **$6,000** family for Out-of-Network Doesn't apply to Prescription Drugs, In-Network Preventive Care, and Copayments. In-Network Provider and Non- Network Provider deductibles are separate.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$6,000** individual / **$12,000** family for Network **$12,000** individual / **$24,000** family for Out-of-Network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for your health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, Prior Authorization, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.cigna.com** or call **833-440-7628** for a list of participating providers.	If you use an in-network doctor or health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or

Questions: Call 833-440-7628 or visit us at www.bpatpa.com.

If you aren't clear about any of the underlined terms in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 833-440-7628 to request a copy.

		participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive this service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	40% coinsurance AD	Deductible does not apply to Network Providers.
	Healthiest You	No charge	Not covered	Telephonic Primary Care Services.
	Specialist visit	$50 copay/visit	40% coinsurance AD	Deductible does not apply to Network Providers.
	Other practitioner office visit	Chiropractic Therapy $25 copay/visit	40% coinsurance AD	Limited to 30 visits per year per member.
	Preventive	No charge	40% coinsurance AD	None

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If you have a test	Diagnostic test (x-ray, blood Count work)	Lab/X-Ray – Office 20% coinsurance AD Lab/X-Ray - Outpatient 20% coinsurance AD	40% coinsurance AD	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance AD	40% coinsurance AD	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pharmavail.com. If the member selects a brand drug when a generic equivalent is available, the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent.	Generic	Retail: $15 copay/prescription (30-day supply) Retail: $45 copay/prescription (90-day supply) Home: $38 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Preferred Brand	Retail: $50 copay/prescription (30-day supply) Retail: $150 copay/prescription (90-day supply) Home: $125 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Non-Preferred Brand	Retail: $85 copay/prescription (30-day supply) Retail: $255 copay/prescription (90-day supply) Home: $213 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.

	Specialty drugs	25% coinsurance up to $400 per RX (30-day supply)	Not covered	Please refer to Plan Document.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance AD	40% coinsurance AD	None
	Physician/surgeon fees	20% coinsurance AD	40% coinsurance AD	None
If you need immediate medical attention	Emergency room services	20% coinsurance AD	20% coinsurance AD	None
	Emergency medical transportation	20% coinsurance AD	20% coinsurance AD	None
	Urgent care	$75 copay then 100%	40% coinsurance AD	Deductible does not apply to Network Providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance AD	40% coinsurance AD	None
	Physician/surgeon fee	20% coinsurance AD	40% coinsurance AD	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit $25 copay/visit Visit – Facility Charges 20% coinsurance AD	40% coinsurance AD	Deductible does not apply to Office Network Providers.
	Mental/Behavioral health inpatient services	20% coinsurance AD	40% coinsurance AD	None

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	Substance use disorder outpatient services	Office Visit $25 copay/visit Visit – Facility Charges 20% coinsurance AD	40% coinsurance AD	Deductible does not apply to Office Network Providers.
	Substance use disorder inpatient services	20% coinsurance AD	40% coinsurance AD	None
If you are pregnant	Prenatal and postnatal care	$25 copay/visit	40% coinsurance AD	Deductible does not apply to Network Providers.
	Delivery and all inpatient services	20% coinsurance AD	40% coinsurance AD	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance AD	40% coinsurance AD	Limited to 100 visits per year.
	Rehabilitation services	20% coinsurance AD	40% coinsurance AD	Coverage is limited to 30 visits per year for physical therapy, occupational therapy combined and 30 visits per year for speech therapy. Limit doesn't apply to autism services.
	Habilitation services	20% coinsurance AD	40% coinsurance AD	Limited to 30 visits per year.
	Skilled nursing care	20% coinsurance AD	40% coinsurance AD	100 day maximum per benefit period.
	Durable medical equipment	20% coinsurance AD	40% coinsurance AD	None
	Hospice service	No charge	40% coinsurance AD	None
If your child needs dental or eye care	Eye exam	No charge	No charge	Exam only covered and member may choose any provider. As required by the ACA.
	Glasses	Not covered	Not covered	None
	Dental check-up	No charge	No charge	Exam only covered and member may choose any provider. As required by the ACA.

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Floyd County Public Schools $1,500 Deductible PPO Group Health Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual Family | **Plan Type:** PPO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric surgery • Cosmetic Surgery	• Hearing Aids • Long Term Care • Non-Emergency Care When Traveling Outside the US	• Routine Foot Care • Weight Loss Programs • Dental Care • Infertility Treatment
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Infertility Diagnostic	• Chiropractic Care (limited to: Limited to 30 visits per benefit period.)	• Private-duty Nursing Outpatient services limited to 16 hours per member per year

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **833-440-7628**. 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.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the plan at **833-440-7628**. 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.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 40% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 833-440-7628 or visit us at www.bpatpa.com.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different. See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,520
- **Patient pays** $2,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**
Patient pays:	
Deductibles	$500
Copays	$20
Coinsurance	$1,350
Limits or exclusions	$150
Total	**$2,020**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,760
- **Patient pays** $1,640

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**
Patient pays:	
Deductibles	$500
Copays	$820
Coinsurance	$240
Limits or exclusions	$80
Total	**$1,640**

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Floyd County Public Schools $4,000 Deductible HSA PPO Group Health Plan

Coverage Period: 10/01/2022-9/30/2023

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.bpatpa.com** or by calling **833-440-7628**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,000** individual / **$8,000** family for Network **$8,000** individual / **$16,000** family for Out-of-Network Doesn't apply to In-Network Preventive Care, and Copayments. In-Network Provider and Non- Network Provider deductibles are separate.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$7,000** individual / **$14,000** family for Network **$14,000** individual / **$28,000** family for Out-of-Network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for your health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, Prior Authorization, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.cigna.com** or call **833-440-7628** for a list of participating providers.	If you use an in-network doctor or health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or

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		participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive this service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance AD	40% coinsurance AD	None
	Healthiest You	No charge	Not covered	Telephonic Primary Care Services.
	Specialist visit	20% coinsurance AD	40% coinsurance AD	None
	Other practitioner office visit	Chiropractic Therapy 20% coinsurance AD	40% coinsurance AD	Limited to 30 visits per year per member.
	Preventive	No charge	40% coinsurance AD	None
If you have a test	Diagnostic test (x-ray, blood Count work)	Lab/X-Ray – Office 20% coinsurance AD	40% coinsurance AD	None

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If you aren't clear about any of the underlined terms in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 833-440-7628 to request a copy.

		Lab/X-Ray - Outpatient 20% coinsurance AD		
	Imaging (CT/PET scans, MRIs)	20% coinsurance AD	40% coinsurance AD	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pharmavail.com. If the member selects a brand drug when a generic equivalent is available, the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent.	Generic	Retail: $15 copay/prescription AD (30-day supply) Retail: $45 copay/prescription AD (90-day supply) Home: $38 copay/prescription AD (90-day supply)	Not covered	Please refer to Plan Document.
	Preferred Brand	Retail: $50 copay/prescription AD (30-day supply) Retail: $150 copay/prescription AD (90-day supply) Home: $125 copay/prescription AD (90-day supply)	Not covered	Please refer to Plan Document.
	Non-Preferred Brand	Retail: $85 copay/prescription AD (30-day supply) Retail: $255 copay/prescription AD (90-day supply) Home: $213 copay/prescription AD (90-day supply)	Not covered	Please refer to Plan Document.

	Specialty drugs	25% coinsurance up to $400 per prescription AD (30-day supply)	Not covered	Please refer to Plan Document.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance AD	40% coinsurance AD	None
	Physician/surgeon fees	20% coinsurance AD	40% coinsurance AD	None
If you need immediate medical attention	Emergency room services	20% coinsurance AD	20% coinsurance AD	None
	Emergency medical transportation	20% coinsurance AD	20% coinsurance AD	None
	Urgent care	20% coinsurance AD	40% coinsurance AD	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance AD	40% coinsurance AD	Prior authorization is required.
	Physician/surgeon fee	20% coinsurance AD	40% coinsurance AD	50% coinsurance for anesthesia
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit 20% coinsurance AD Visit – Facility Charges 20% coinsurance AD	40% coinsurance AD	None
	Mental/Behavioral health inpatient services	20% coinsurance AD	40% coinsurance AD	None
	Substance use disorder outpatient services	Office Visit 20% coinsurance AD	40% coinsurance AD	None

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		Visit – Facility Charges 20% coinsurance AD		
	Substance use disorder inpatient services	20% coinsurance AD	40% coinsurance AD	None
If you are pregnant	Prenatal and postnatal care	20% coinsurance AD	40% coinsurance AD	None
	Delivery and all inpatient services	20% coinsurance AD	40% coinsurance AD	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance AD	40% coinsurance AD	Limited to 100 visits per year.
	Rehabilitation services	20% coinsurance AD	40% coinsurance AD	Coverage is limited to 30 visits per year for physical therapy, occupational therapy combined and 30 visits per year for speech therapy. Limit doesn't apply to autism services.
	Habilitation services	20% coinsurance AD	40% coinsurance AD	Limited to 30 visits per year.
	Skilled nursing care	20% coinsurance AD	40% coinsurance AD	100 day maximum per benefit period.
	Durable medical equipment	20% coinsurance AD	40% coinsurance AD	None
	Hospice service	20% coinsurance AD	40% coinsurance AD	None
If your child needs dental or eye care	Eye exam	No charge	No charge	Exam only covered and member may choose any provider. As required by the ACA.
	Glasses	Not covered	Not covered	None
	Dental check-up	No charge	No charge	Exam only covered and member may choose any provider. As required by the ACA.

Floyd County Public Schools $4,000 Deductible HSA PPO Group Health Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual Family | **Plan Type:** PPO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric surgery • Cosmetic Surgery	• Hearing Aids • Long Term Care • Non-Emergency Care When Traveling Outside the US	• Routine Foot Care • Weight Loss Programs • Dental Care • Infertility Treatment
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Infertility Diagnostic	• Chiropractic Care (limited to: Limited to 30 visits per benefit period.)	• Private-duty Nursing Outpatient services limited to 16 hours per member per year

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **833-440-7628**. 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.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the plan at **833-440-7628**. 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.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 40% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 833-440-7628 or visit us at www.bpatpa.com.

If you aren't clear about any of the underlined terms in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 833-440-7628 to request a copy.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,370
- **Patient pays** $4,170

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**
Patient pays:	
Deductibles	$20
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,470
- **Patient pays** $2,930

Sample care costs:	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**
Patient pays:	
Deductibles	$2,850
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,930**

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Floyd County Public Schools $5,500 Deductible PPO Group Health Plan

Coverage Period: 10/01/2022-9/30/2023

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.bpatpa.com** or by calling **833-440-7628**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5,500** individual / **$11,000** family for Network **$11,000** individual / **$22,000** family for Out-of-Network Doesn't apply to Prescription Drugs, In-Network Preventive Care, and Copayments. In-Network Provider and Non- Network Provider deductibles are separate.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, for Prescription Drugs. $250 individual/$500 family. Deductible only applies to Tiers 2, 3 and 4.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$8,700** individual / **$17,400** family for Network **$17,400** individual / **$34,800** family for Out-of-Network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for your health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, Prior Authorization, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.cigna.com** or call **833-440-7628** for a list of participating providers.	If you use an in-network doctor or health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or

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		participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive this service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 copay/visit	40% coinsurance AD	Deductible does not apply to Network Providers.
	Healthiest You	No charge	Not covered	Telephonic Primary Care Services.
	Specialist visit	$70 copay/visit	40% coinsurance AD	Deductible does not apply to Network Providers.
	Other practitioner office visit	Chiropractic Therapy $45 copay/visit	40% coinsurance AD	Limited to 30 visits per year per member.
	Preventive	No charge	40% coinsurance AD	None

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If you have a test	Diagnostic test (x-ray, blood Count work)	Lab/X-Ray – Office 20% coinsurance AD Lab/X-Ray - Outpatient 20% coinsurance AD	40% coinsurance AD	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance AD	40% coinsurance AD	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pharmavail.com. If the member selects a brand drug when a generic equivalent is available, the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent.	Generic	Retail: $15 copay/prescription (30-day supply) Retail: $45 copay/prescription (90-day supply) Home: $38 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Preferred Brand	Retail: $50 copay/prescription AD (30-day supply) Retail: $150 copay/prescription AD (90-day supply) Home: $125 copay/prescription AD (90-day supply)	Not covered	Please refer to Plan Document.
	Non-Preferred Brand	Retail: $85 copay/prescription AD (30-day supply) Retail: $255 copay/prescription AD (90-day supply) Home: $213 copay/prescription AD (90-day supply)	Not covered	Please refer to Plan Document.

	Specialty drugs	25% coinsurance up to $400 per prescription AD (30-day supply)	Not covered	Please refer to Plan Document.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay/visit	40% coinsurance AD	None
	Physician/surgeon fees	20% coinsurance AD	40% coinsurance AD	None
If you need immediate medical attention	Emergency room services	20% coinsurance AD	20% coinsurance AD	None
	Emergency medical transportation	20% coinsurance AD	20% coinsurance AD	None
	Urgent care	$75 copay then 100%	40% coinsurance AD	Deductible does not apply to Network Providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance AD	40% coinsurance AD	None
	Physician/surgeon fee	20% coinsurance AD	40% coinsurance AD	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit $45 copay/visit Visit – Facility Charges 20% coinsurance AD	40% coinsurance AD	Deductible does not apply to Office Network Providers.
	Mental/Behavioral health inpatient services	20% coinsurance AD	40% coinsurance AD	None

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	Substance use disorder outpatient services	Office Visit $45 copay/visit Visit – Facility Charges 20% coinsurance AD	40% coinsurance AD	Deductible does not apply to Office Network Providers.
	Substance use disorder inpatient services	20% coinsurance AD	40% coinsurance AD	None
If you are pregnant	Prenatal and postnatal care	$45 copay/visit	40% coinsurance AD	Deductible does not apply to Network Providers.
	Delivery and all inpatient services	20% coinsurance AD	40% coinsurance AD	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance AD	40% coinsurance AD	Limited to 100 visits per year.
	Rehabilitation services	20% coinsurance AD	40% coinsurance AD	Coverage is limited to 30 visits per year for physical therapy, occupational therapy combined and 30 visits per year for speech therapy. Limit doesn't apply to autism services.
	Habilitation services	20% coinsurance AD	40% coinsurance AD	Limited to 30 visits per year.
	Skilled nursing care	20% coinsurance AD	40% coinsurance AD	100 day maximum per benefit period.
	Durable medical equipment	20% coinsurance AD	40% coinsurance AD	None
	Hospice service	No charge	40% coinsurance AD	None
If your child needs dental or eye care	Eye exam	No charge	No charge	Exam only covered and member may choose any provider. As required by the ACA.
	Glasses	Not covered	Not covered	None
	Dental check-up	No charge	No charge	Exam only covered and member may choose any provider. As required by the ACA.

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Floyd County Public Schools $5,500 Deductible PPO Group Health Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual Family | **Plan Type:** PPO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric surgery • Cosmetic Surgery	• Hearing Aids • Long Term Care • Non-Emergency Care When Traveling Outside the US	• Routine Foot Care • Weight Loss Programs • Dental Care • Infertility Treatment
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Infertility Diagnostic	• Chiropractic Care (limited to: Limited to 30 visits per benefit period.)	• Private-duty Nursing Outpatient services limited to 16 hours per member per year

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **833-440-7628**. 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.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the plan at **833-440-7628**. 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.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 40% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 833-440-7628 or visit us at www.bpatpa.com.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different. See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,520
- **Patient pays** $2,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$20
Coinsurance	$1,350
Limits or exclusions	$150
Total	**$2,020**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,760
- **Patient pays** $1,640

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$820
Coinsurance	$240
Limits or exclusions	$80
Total	**$1,640**

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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