# 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<br>**$8,000** individual / **$16,000** family for Out-of-Network<br><br>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<br>**$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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| | | | | |
|---|---|---|---|---|
| | | Lab/X-Ray - Outpatient<br>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)<br>Retail: $45 copay/prescription AD (90-day supply)<br>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)<br>Retail: $150 copay/prescription AD (90-day supply)<br>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)<br>Retail: $255 copay/prescription AD (90-day supply)<br>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<br>20% coinsurance AD<br>Visit – Facility Charges<br>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<br>20% coinsurance AD | 40% coinsurance AD | None |

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| | | | | |
|---|---|---|---|---|
| | | Visit – Facility Charges<br>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. |

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**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<br>• Bariatric surgery<br>• Cosmetic Surgery | • Hearing Aids<br>• Long Term Care<br>• Non-Emergency Care When Traveling Outside the US | • Routine Foot Care<br>• Weight Loss Programs<br>• Dental Care<br>• 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.*

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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** $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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