Tazewell County Public Schools $1,000 Deductible Group Health Plan

Coverage Period 10/1/2022 - 09/30/2023

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 **800-277-8973**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** individual / **$2,000** family for Network **$1,500** individual / **$3,000** 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. **$5,000** individual / **$10,000** family for Network **$6,250** individual / **$12,500** 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 **800-277-8973** 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 copay/visit	40% coinsurance AD	Plan Year deductible does not apply
	Healthiest You	No charge	Not covered	Telephonic Primary Care Services.
	Specialist visit	$40 copay/visit	40% coinsurance AD	Plan Year deductible does not apply
	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 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.express-scripts.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: $10 copay/prescription (30-day supply) Mail: $25 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Preferred Brand	Retail: $30 copay/prescription (30-day supply) Mail: $75 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Non-Preferred Brand	Retail: $50 copay/prescription (30-day supply) Mail: $125 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Specialty drugs	Retail: $125 copay/prescription (30-day supply) Mail: $125 copay/prescription (90-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

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	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	$40 copay/visit	40% coinsurance AD	Plan Year deductible does not apply
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 $20 copay/visit Visit – Facility Charges 20% coinsurance AD	40% coinsurance AD	Plan Year deductible does not apply
	Mental/Behavioral health inpatient services	20% coinsurance AD	40% coinsurance AD	Plan Year deductible does not apply
	Substance use disorder outpatient services	Office Visit $20 copay/visit Visit – Facility Charges 20% coinsurance AD	40% coinsurance AD	Plan Year deductible does not apply
	Substance use disorder inpatient services	20% coinsurance AD	40% coinsurance AD	Plan Year deductible does not apply
If you are pregnant	Prenatal and postnatal care	$20 copay for Diagnosis and then 20% coinsurance AD	40% coinsurance AD	Plan Year deductible does not apply. Dependent daughters are covered.
	Delivery and all	20% coinsurance AD	40% coinsurance AD	Dependent daughters are covered.

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	inpatient services			
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 90 visits per year for physical therapy, occupational therapy and speech therapy combined. Limit does not 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	Limited to a 100 day/stay.
	Durable medical equipment	20% coinsurance AD	40% coinsurance AD	Covered up to the purchase price
	Hospice service	No charge	40% coinsurance AD	Plan Year deductible does not apply
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.

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
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.)		
• Chiropractic Care (limited to: Limited to 30 visits per benefit period.)	• Infertility Treatment (limited to: diagnostic work to determine diagnosis only) • Private-duty Nursing	• Routine Eye Care (Adult) (limited to: In and Out of Network: $15 copayment and payable at 100%)

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 **800-277-8973**. 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 **800-277-8973**. 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** $5,190
- **Patient pays** $2,350

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	$0
Copays	$20
Coinsurance	$2,180
Limits or exclusions	$150
Total	**$2,350**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,190
- **Patient pays** $1,210

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	$0
Copays	$400
Coinsurance	$730
Limits or exclusions	$80
Total	**$1,210**

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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Tazewell County Public Schools $3,000 HSA Deductible Group Health Plan

Coverage Period 10/1/2022 - 09/30/2023

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 **800-277-8973**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** individual / **$6,000** family for Network **$6,000** individual / **$12,000** 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. **$5,000** individual / **$10,000** family for Network **$10,000** individual / **$20,000** 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 **800-277-8973** 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 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.express-scripts.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: 20% coinsurance AD (30-day supply) Mail: 20% coinsurance AD (90-day supply)	Not covered	Please refer to Plan Document.
	Preferred Brand	Retail: 20% coinsurance AD (30-day supply) Mail: 20% coinsurance AD (90-day supply)	Not covered	Please refer to Plan Document.
	Non-Preferred Brand	Retail: 20% coinsurance AD (30-day supply) Mail: 20% coinsurance AD (90-day supply)	Not covered	Please refer to Plan Document.
	Specialty drugs	Retail: 20% coinsurance AD (30-day supply) Mail: 20% coinsurance AD (90-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

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	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	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 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 Visit – Facility Charges 20% coinsurance AD	40% coinsurance AD	None
	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	Dependent daughters are covered.
	Delivery and all	20% coinsurance AD	40% coinsurance AD	Dependent daughters are covered.

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	inpatient services			
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 90 visits per year for physical therapy, occupational therapy and speech therapy combined. Limit does not 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	Limited to a 100 day/stay.
	Durable medical equipment	20% coinsurance AD	40% coinsurance AD	Covered up to the purchase price
	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.

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
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.)		
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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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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** $5,190
- **Patient pays** $2,350

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	$0
Copays	$20
Coinsurance	$2,180
Limits or exclusions	$150
Total	**$2,350**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,190
- **Patient pays** $1,210

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	$0
Copays	$400
Coinsurance	$730
Limits or exclusions	$80
Total	**$1,210**

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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Tazewell County Public Schools $5,500 Deductible Group Health Plan

Coverage Period 10/1/2022 - 09/30/2023

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 **800-277-8973**.

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?	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. **$6,450** individual / **$12,900** family for Network **$12,900** individual / **$25,800** 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 **800-277-8973** 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 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.express-scripts.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: $10 copay/prescription (30-day supply) Mail: $25 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Preferred Brand	Retail: $40 copay/prescription (30-day supply) Mail: $100 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Non-Preferred Brand	Retail: $70 copay/prescription (30-day supply) Mail: $175 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Specialty drugs	Retail: 25% coinsurance up to $250 max (30-day supply) Mail: 25% coinsurance up to $250 max (90-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	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 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 Visit – Facility Charges 20% coinsurance AD	40% coinsurance AD	None
	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	Dependent daughters are covered.
	Delivery and all	20% coinsurance AD	40% coinsurance AD	Dependent daughters are covered.

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	inpatient services			
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 90 visits per year for physical therapy, occupational therapy and speech therapy combined. Limit does not 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	Limited to a 100 day/stay.
	Durable medical equipment	20% coinsurance AD	40% coinsurance AD	Covered up to the purchase price
	Hospice service	No charge	40% coinsurance AD	Plan Year deductible does not apply
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.

Tazewell County Public Schools $5,500 Deductible 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
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.)		
• Chiropractic Care (limited to: Limited to 30 visits per benefit period.)	• Infertility Treatment (limited to: diagnostic work to determine diagnosis only) • Private-duty Nursing	• Routine Eye Care (Adult) (limited to: In and Out of Network: $15 copayment and payable at 100%)

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 **800-277-8973**. 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 **800-277-8973**. 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** $5,190
- **Patient pays** $2,350

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	$0
Copays	$20
Coinsurance	$2,180
Limits or exclusions	$150
Total	**$2,350**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,190
- **Patient pays** $1,210

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	$0
Copays	$400
Coinsurance	$730
Limits or exclusions	$80
Total	**$1,210**

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