

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 <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket</u> <u>limit</u> on my expenses?	Yes. \$5,000 individual / \$10,000 family for Network \$6,250 individual / \$12,500 family for Out-of-Network	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket</u> <u>limit</u> ?	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 <i>specific</i> 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 innetwork 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	Complete Voy May Need	Your Cost If You Use a		Limitations 9 Eventions
Event	Services You May Need	Network Provider	Out-Of-Network Provider	Limitations & Exceptions
	Primary care visit to treat an injury or illness	\$20 copay/visit	40% coinsurance AD	Plan Year deductible does not apply
If you visit a	Healthiest You	No charge	Not covered	Telephonic Primary Care Services.
health care provider's	Specialist visit	\$40 copay/visit	40% coinsurance AD	Plan Year deductible does not apply
office or clinic	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)	<u>Lab/X-Ray – Office</u> 20% coinsurance AD	40% coinsurance AD	None

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		<u>Lab/X-Ray - Outpatient</u> 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	Generic	Retail: \$10 copay/prescription (30-day supply) Mail: \$25 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.	
about prescription drug coverage is available at www.express-	Preferred Brand	Retail: \$30 copay/prescription (30-day supply) Mail: \$75 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.	
scripts.com. If the member selects a brand drug when a generic equivalent	Non-Preferred Brand	Retail: \$50 copay/prescription (30-day supply) Mail: \$125 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.	
is available, the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent.	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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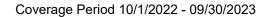


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	Physician/surgeon fees	20% coinsurance AD	40% coinsurance AD	None
	Emergency room services	20% coinsurance AD	20% coinsurance AD	None
If you need immediate medical attention	Emergency medical transportation	20% coinsurance AD	20% coinsurance AD	None
	Urgent care	\$40 copay/visit	40% coinsurance AD	Plan Year deductible does not apply
If you have a	Facility fee (e.g., hospital room)	20% coinsurance AD	40% coinsurance AD	None
hospital stay	Physician/surgeon fee	20% coinsurance AD	40% coinsurance AD	None
	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
If you have mental health,	Mental/Behavioral health inpatient services	20% coinsurance AD	40% coinsurance AD	Plan Year deductible does not apply
behavioral health, or substance abuse needs	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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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

	inpatient services			
If you need help recovering or	Home health care	20% coinsurance AD	40% coinsurance AD	Limited to 100 visits per year.
		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.
have other s		20% coinsurance AD	40% coinsurance AD	Limited to 30 visits per year.
health needs	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.
	11-120000	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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bestlife Tazewell County Public Schools \$1,000 Deductible Group Health Plan

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

Excluded Services & Other Covered 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.cciio.cms.gov. 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 800-277-8973 or visit us at www.bpatpa.com.



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

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

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:

\$2,700
\$2,100
\$900
\$900
\$500
\$200
\$200
\$40
\$7,540
\$0
\$20
\$2,180
\$150
\$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
Copays Coinsurance	\$400 \$730
' '	•
Coinsurance	\$730

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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 <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> 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?

<u>No.</u> Coverage Examples are <u>not</u> 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 <u>providers</u> charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

<u>Yes</u>. 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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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 <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket</u> <u>limit</u> on my expenses?	Yes. \$5,000 individual / \$10,000 family for Network \$10,000 individual / \$20,000 family for Out-of-Network	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket</u> <u>limit?</u>	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 <i>specific</i> 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 innetwork doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or

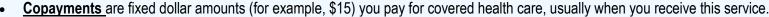
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		participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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 .



- Coinsurance is your share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> 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 <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)

• This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical	Your Cost If You Use a		Limitationa & Evacationa	
Event	Services You May Need	Network Provider	Out-Of-Network Provider	Limitations & Exceptions
	Primary care visit to treat an injury or illness	20% coinsurance AD	40% coinsurance AD	None
If you visit a health care provider's	Healthiest You	No charge	Not covered	Telephonic Primary Care Services.
	Specialist visit	20% coinsurance AD	40% coinsurance AD	None
office or clinic	Other practitioner office visit	<u>Chiropractic Therapy</u> 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)	<u>Lab/X-Ray – Office</u> 20% coinsurance AD	40% coinsurance AD	None

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

Coverage for: Individual Family | Plan Type: PPO

		<u>Lab/X-Ray - Outpatient</u> 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	Generic	Retail: 20% coinsurance AD (30-day supply) Mail: 20% coinsurance AD (90-day supply)	Not covered	Please refer to Plan Document.
about prescription drug coverage is available at www.express-	Preferred Brand	Retail: 20% coinsurance AD (30-day supply) Mail: 20% coinsurance AD (90-day supply)	Not covered	Please refer to Plan Document.
scripts.com. If the member selects a brand drug when a generic equivalent	Non-Preferred Brand	Retail: 20% coinsurance AD (30-day supply) Mail: 20% coinsurance AD (90-day supply)	Not covered	Please refer to Plan Document.
is available, the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent.	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

Questions: Call 800-277-8973 or visit us at www.bpatpa.com.

Dependent daughters are covered.

Dependent daughters are covered.



If you are pregnant

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

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

Coverage for: Individual Family | Plan Type: PPO Physician/surgeon fees 20% coinsurance AD None 40% coinsurance AD 20% coinsurance AD Emergency room services 20% coinsurance AD None If you need Emergency medical immediate medical 20% coinsurance AD 20% coinsurance AD None transportation attention Urgent care 20% coinsurance AD 40% coinsurance AD None Facility fee 20% coinsurance AD 40% coinsurance AD If you have a None (e.g., hospital room) hospital stay 40% coinsurance AD Physician/surgeon fee 20% coinsurance AD None Office Visit Mental/Behavioral health 20% coinsurance AD None Visit - Facility Charges 40% coinsurance AD outpatient services 20% coinsurance AD If you have mental Mental/Behavioral health 40% coinsurance AD 20% coinsurance AD None health, inpatient services behavioral health, Office Visit or substance abuse Substance use disorder 20% coinsurance AD needs None outpatient services Visit – Facility Charges 40% coinsurance AD 20% coinsurance AD Substance use disorder 20% coinsurance AD 40% coinsurance AD None inpatient services

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Delivery and all

Prenatal and postnatal care

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 800-277-8973 to request a copy.

40% coinsurance AD

40% coinsurance AD

20% coinsurance AD

20% coinsurance AD



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

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Coverage for: Individual Family Plan Type: PPC				
e AD	Limited to 100 visits per year.			
e 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.			
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	inpatient services			
	Home health care	20% coinsurance AD	40% coinsurance AD	Limited to 100 visits per year.
If you need help recovering or	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.
have other special	Habilitation services	20% coinsurance AD	40% coinsurance AD	Limited to 30 visits per year.
health needs	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.

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

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

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cove	(This isn't a comple	ete list. Check your p	policy or plan	document for other	excluded services.)
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- 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:

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

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.



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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:

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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: Call 800-277-8973 or visit us at www.bpatpa.com.



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

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

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 <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> 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?

<u>No.</u> Coverage Examples are <u>not</u> 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 <u>providers</u> charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

<u>Yes</u>. 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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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 <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket</u> <u>limit</u> on my expenses?	Yes. \$6,450 individual / \$12,900 family for Network \$12,900 individual / \$25,800 family for Out-of-Network	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket</u> <u>limit</u> ?	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 <i>specific</i> 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 innetwork doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or

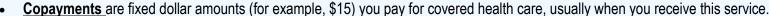
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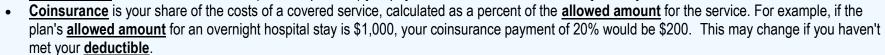


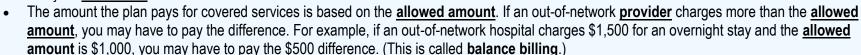
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual Family | Plan Type: PPO

		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 .



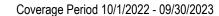




• This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical	Complete Very May Need	Your Cost If You Use a		Limitations 9 Freedings
Event	Services You May Need	Network Provider	Out-Of-Network Provider	Limitations & Exceptions
	Primary care visit to treat an injury or illness	20% coinsurance AD	40% coinsurance AD	None
If you visit a health care provider's office or clinic	Healthiest You	No charge	Not covered	Telephonic Primary Care Services.
	Specialist visit	20% coinsurance AD	40% coinsurance AD	None
	Other practitioner office visit	<u>Chiropractic Therapy</u> 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)	<u>Lab/X-Ray – Office</u> 20% coinsurance AD	40% coinsurance AD	None

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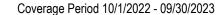


Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual Family | Plan Type: PPO

-				7, 7,
		<u>Lab/X-Ray - Outpatient</u> 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	Generic	Retail: \$10 copay/prescription (30-day supply) Mail: \$25 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
about prescription drug coverage is available at	Preferred Brand	Retail: \$40 copay/prescription (30-day supply) Mail: \$100 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
www.express- scripts.com. If the member selects a brand drug when a generic equivalent	Non-Preferred Brand	Retail: \$70 copay/prescription (30-day supply) Mail: \$175 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
is available, the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent.	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

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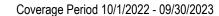


bpa bestlife Tazewell County Public Schools \$5,500 Deductible Group Health Plan

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

immary of benefits and coverage: what this Plan Covers & what it costs			Coverage for: individual Family Plan Type: PPC	
	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	Facility fee (e.g., hospital room)	20% coinsurance AD	40% coinsurance AD	None
hospital stay	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.

Questions: Call 800-277-8973 or visit us at www.bpatpa.com.



Plan Year deductible does not apply

Exam only covered and member may choose

any provider. As required by the ACA.

None

Exam only covered and member may choose

any provider. As required by the ACA.



If your child needs

dental or eye care

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

No charge

No charge

Not covered

No charge

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

-				
	inpatient services			
	Home health care	20% coinsurance AD	40% coinsurance AD	Limited to 100 visits per year.
If you need help recovering or	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.
have other special	Habilitation services	20% coinsurance AD	40% coinsurance AD	Limited to 30 visits per year.
health needs	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

40% coinsurance AD

No charge

Not covered

No charge

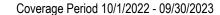
Questions: Call 800-277-8973 or visit us at www.bpatpa.com.

Hospice service

Dental check-up

Eye exam

Glasses





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

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

Excluded Services & Other Covered 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.cciio.cms.gov. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

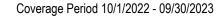
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

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

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

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:	
	Φ0
Deductibles	\$0
Deductibles Copays	\$0 \$400
Copays	\$400
Copays Coinsurance	\$400 \$730

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

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

Questions and Answers about the Coverage Examples:

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