

Banks County Board of Commissioners Health Protection Plan: Plan C

Coverage Period: July 1, 2022 – June 30, 2023

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

Coverage for: Employee, Spouse, Children |

Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost of covered health services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. 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.benefitsupport.biz or by calling (770) 532-2690. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Defined Terms section of the plan document or summary plan description.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	\$5,000 person / \$10,000 family for Network providers, \$10,000 person / \$20,000 family non-Network providers. Per Calendar Year (January 1 st) Doesn't include Coinsurance; copayments; prior authorization and cost containment penalties; premiums don't count toward the deductible .	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this health insurance <u>plan</u> begins to pay for covered services you use. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . See the chart titled Common Medical Event for how much you pay for covered services after you meet the deductible .
Are there services covered before you meet your <u>deductibles</u>?	Yes. <u>Preventive Care Services</u> and categories with a <u>copay</u> are covered before you meet your deductible.	The <u>plan</u> covers some items and services even if you haven't met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
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 titled Common Medical Event for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$7,900 person / \$15,800 family for Network providers, \$12,000 person / \$24,000 family for non-Network providers.	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. Calendar Year Deductible, Medical Services coinsurance, medical and prescription copayments all apply toward the Medical Services Maximum Calendar Year Out-Of-Pocket. Out-Of-Pockets for Network and Non-Network Providers do cross apply. This limit helps you plan for health care expenses. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

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What is not included in the <u>out-of-pocket limit</u> ?	Premiums, deductibles, prior authorization and cost containment penalties, amounts over allowed amount, (balance-billed charges for non-Network providers) and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the insurer pays?	No.	The chart titled Common Medical Event describes <i>specific</i> coverage limits such as limits on the number of office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of Network Providers, see www.benefitsupport.biz or call (770) 532-2690.	If you use a Network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Beware, your Network <u>provider</u> may use an out-of-Network <u>provider</u> for some services. Plans use the term panel, in-network, preferred, or participating for <u>providers</u> in their <u>network</u> . See the chart titled Common Medical Event for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> 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 in the box titled Services Your Plan Does Not Cover. See your policy or plan document for information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the 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 Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copay</u> per visit, <u>Deductible</u> does not apply	40% <u>coinsurance</u>	includes visit, in office lab, xray, injections and office surgical procedures
	Specialist office visit	\$70 <u>copay</u> per visit, <u>Deductible</u> does not apply	40% <u>coinsurance</u>	includes visit, in office lab, xray, injections and office surgical procedures
	Preventive care / screening / immunization	0% coinsurance Deductible Waived	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Outpatient Diagnostic Standard test (x-ray, blood work)	0% coinsurance Deductible Waived	Lab Testing: Not Covered X-ray/Diagnostics: 30% <u>coinsurance</u>	
	Advanced Imaging (CT/PET scans, MRIs)	20% coinsurance	\$500 copay per occurrence, then 40% coinsurance after deductible	<u>Preauthorization</u> is required <u>out-of-network</u> or benefits reduces to 50% of <u>allowed amount</u> .

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at (770) 532-2690	Tier 1 – Your Lowest Cost Option	Retail: \$10 <u>copay</u> , <u>Deductible</u> does not apply Mail Order: \$25 <u>copay</u> <u>Deductible</u> does not apply	Retail: \$10 <u>copay</u> , <u>Deductible</u> does not apply	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: up to a 90 day supply or Preferred 90 Day Retail <u>Network Pharmacy</u> . You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain preventative medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under you policy being available for certain prescribed drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$50 <u>copay</u> , Mail Order: \$125 <u>copay</u>	Retail: \$50 <u>copay</u> ,	
	Tier 3 - Your Mid-Range Cost Option	Retail: \$150 <u>copay</u> , Mail Order: \$375 <u>copay</u>	Retail: \$150 <u>copay</u> ,	
	Tier 4 – Your Highest Cost Option	Retail: \$300 <u>copay</u> , Mail Order: \$750 <u>copay</u>	Retail: \$300 <u>copay</u> ,	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 copay, then 100% (Deductible and coinsurance do not apply)	40% coinsurance	<u>Preauthorization</u> is required <u>out-of-network</u> or benefits reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance	*20% coinsurance	* <u>Network Deductible</u> applies
	Emergency medical transportation	0% coinsurance	*20% coinsurance	* <u>Network Deductible</u> applies
	Urgent care	\$75 <u>copay</u> per visit <u>Deductible</u> does not apply	40% coinsurance	If you receive services in addition to Urgent Care visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery

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If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay per occurrence, then 20% coinsurance	40% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by \$500. <u>Preauthorization</u> is required <u>out-of-network</u> or benefits reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$35 <u>copay</u> per visit, <u>Deductible</u> does not apply	40% coinsurance	<u>Network</u> Partial <u>hospitalization</u> /intensive outpatient treatment: 0% <u>coinsurance</u> . <u>Preauthorization</u> is required <u>out-of-network</u> or benefits reduces to 50% of <u>allowed amount</u> . See your policy or <u>plan</u> document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	40% coinsurance	Prior authorization required Penalties for failure to get prior authorization: benefit payment reduced by \$500. <u>Preauthorization</u> is required <u>out-of-network</u> or benefits reduces to 50% of <u>allowed amount</u> . See your policy or <u>plan</u> document for additional information about EAP benefits.
If you are pregnant	Office Visits	0% coinsurance	30% coinsurance	<u>Cost sharing</u> does not apply for <u>preventive services</u>
	Delivery and all inpatient services Professional services	20% coinsurance	40% coinsurance	Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include test and services described elsewhere in the SBC (i.e. ultrasound).
	Delivery and all inpatient services Facility services	20% coinsurance	40% coinsurance	\$500 per occurrence <u>deductible</u> applies prior to the overall <u>deductible</u> . Inpatient <u>Preauthorization</u> applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> .
If you need help recovering or have other special health	Home health care	20% coinsurance	40% coinsurance	Limited to 60 visits per Calendar Year. <u>Preauthorization</u> is required <u>out-of-network</u> or benefits reduces to 50% of <u>allowed amount</u> .

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
needs	Rehabilitation services Occupational, Speech and Physical Therapy	\$35 copay per visit, <u>Deductible</u> does not apply	40% coinsurance	Limits per Calendar year: Physical, Occupational and Speech: 37 visits Cardiac: 36 visits Pulmonary: 20 visits No limits apply for treatment of Autism Spectrum Disorder Services for children under the age of 20.
	Habilitation services	\$35 copay per visit, <u>Deductible</u> does not apply	40% coinsurance	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. No limits apply for treatment of Autism Spectrum Disorder Services for children under the age of 20.
	Skilled nursing care	20% coinsurance	40% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by \$500. Limited to 60 days per Calendar Year (combined with Inpatient Rehabilitation) <u>Preauthorization</u> is required <u>out-of-network</u> or benefits reduces to 50% of <u>allowed amount</u> .
	Durable medical equipment	20% coinsurance	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years. No coverage <u>out-of-network</u> .
	Hospice service	20% coinsurance	40% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by \$500. <u>Preauthorization</u> is required <u>out-of-network</u> or benefits reduces to 50% of <u>allowed amount</u> .
If your child needs dental or eye care	Eye exam	Not covered	Not covered	No coverage for Children's eye exams
	Glasses	Not covered	Not covered	No coverage for Children's glasses
	Dental check-up	Not covered	Not covered	No coverage for Children's dental check up.

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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 <u>excluded services</u> .)		
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care	<ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S. if travel is for the sole purpose of obtaining medical services	<ul style="list-style-type: none">• Routine eye care (Adult)• Routine foot care – Except as covered for Diabetes• Weight loss programs
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.)		
<ul style="list-style-type: none">• Chiropractic care (manipulative care) 20 visits per Calendar year.	<ul style="list-style-type: none">• Hearing aids	

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 (770) 532-2690. 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 sponsor at (770) 532-2690 or the plan's Claims administrator at (770) 532-2690, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 does provide minimum essential coverage.**

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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 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'

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

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Coverage Examples

Coverage for: Employee, Spouse, Children | Plan Type: PPO

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)																																										
<ul style="list-style-type: none"> ■ The <u>plan's</u> overall <u>deductible</u> \$5,000 ■ <u>Specialist Copay</u> \$70 ■ Hospital (facility) <u>coinsurance</u> 20% ■ Other <u>coinsurance</u> 20% 	<ul style="list-style-type: none"> ■ The <u>plan's</u> overall <u>deductible</u> \$5,000 ■ <u>Specialist Copay</u> \$760 ■ Hospital (facility) <u>coinsurance</u> 20% ■ Other <u>coinsurance</u> 20% 	<ul style="list-style-type: none"> ■ The <u>plan's</u> overall <u>deductible</u> \$5,000 ■ <u>Specialist Copay</u> \$760 ■ Hospital (facility) <u>coinsurance</u> 20% ■ Other <u>coinsurance</u> 20% 																																										
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>	<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>	<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>																																										
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="background-color: #ADD8E6;">Total Example Cost</td> <td style="text-align: right;">\$12,700</td> </tr> </table>	Total Example Cost	\$12,700	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="background-color: #ADD8E6;">Total Example Cost</td> <td style="text-align: right;">\$5,600</td> </tr> </table>	Total Example Cost	\$5,600	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="background-color: #ADD8E6;">Total Example Cost</td> <td style="text-align: right;">\$2,800</td> </tr> </table>	Total Example Cost	\$2,800																																				
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<p>In this example, Peg would pay:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="background-color: #ADD8E6;"><i>Cost Sharing</i></th> </tr> <tr> <td>Deductibles</td> <td style="text-align: right;">\$5,000</td> </tr> <tr> <td>Copayments</td> <td style="text-align: right;">\$10</td> </tr> <tr> <td>Coinsurance</td> <td style="text-align: right;">\$1,300</td> </tr> <tr> <th colspan="2" style="background-color: #ADD8E6;"><i>What isn't covered</i></th> </tr> <tr> <td>Limits or exclusions</td> <td style="text-align: right;">\$60</td> </tr> <tr> <td style="background-color: #ADD8E6;">The total Peg would pay is</td> <td style="text-align: right;">\$6,370</td> </tr> </table>	<i>Cost Sharing</i>		Deductibles	\$5,000	Copayments	\$10	Coinsurance	\$1,300	<i>What isn't covered</i>		Limits or exclusions	\$60	The total Peg would pay is	\$6,370	<p>In this example, Joe would pay:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="background-color: #ADD8E6;"><i>Cost Sharing</i></th> </tr> <tr> <td>Deductibles</td> <td style="text-align: right;">\$500</td> </tr> <tr> <td>Copayments</td> <td style="text-align: right;">\$1,200</td> </tr> <tr> <td>Coinsurance</td> <td style="text-align: right;">\$0</td> </tr> <tr> <th colspan="2" style="background-color: #ADD8E6;"><i>What isn't covered</i></th> </tr> <tr> <td>Limits or exclusions</td> <td style="text-align: right;">\$0</td> </tr> <tr> <td style="background-color: #ADD8E6;">The total Joe would pay is</td> <td style="text-align: right;">\$1,700</td> </tr> </table>	<i>Cost Sharing</i>		Deductibles	\$500	Copayments	\$1,200	Coinsurance	\$0	<i>What isn't covered</i>		Limits or exclusions	\$0	The total Joe would pay is	\$1,700	<p>In this example, Mia would pay:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="background-color: #ADD8E6;"><i>Cost Sharing</i></th> </tr> <tr> <td>Deductibles</td> <td style="text-align: right;">\$2,100</td> </tr> <tr> <td>Copayments</td> <td style="text-align: right;">\$300</td> </tr> <tr> <td>Coinsurance</td> <td style="text-align: right;">\$0</td> </tr> <tr> <th colspan="2" style="background-color: #ADD8E6;"><i>What isn't covered</i></th> </tr> <tr> <td>Limits or exclusions</td> <td style="text-align: right;">\$0</td> </tr> <tr> <td style="background-color: #ADD8E6;">The total Mia would pay is</td> <td style="text-align: right;">\$2,400</td> </tr> </table>	<i>Cost Sharing</i>		Deductibles	\$2,100	Copayments	\$300	Coinsurance	\$0	<i>What isn't covered</i>		Limits or exclusions	\$0	The total Mia would pay is	\$2,400
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Copayments	\$300																																											
Coinsurance	\$0																																											
<i>What isn't covered</i>																																												
Limits or exclusions	\$0																																											
The total Mia would pay is	\$2,400																																											

Questions: Call (770) 532-2690 or visit us at www.benefitsupport.biz.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call (770) 532-2690 to request a copy.