Banks County Board of Commissioners Health Protection Plan: Plan B

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 deductible?	**$3,000** person / **$9,000** family for Network providers, **$6,000** person / **$18,000** family non-Network providers. Per Calendar Year (January 1st) 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 providers up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. 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 deductibles?	Yes. Preventive Care Services and categories with a copay are covered before you meet your deductible.	The plan covers some items and services even if you haven't met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart titled Common Medical Event for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$7,900** person / **$15,800** family for Network providers, **$12,000** person / **$24,000** family for non-Network providers.	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. 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 plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	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 **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays?	No.	The chart titled Common Medical Event describes *specific* coverage limits such as limits on the number of office visits.
Does this plan use a network of providers?	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 **provider** may use an out-of-Network **provider** for some services. Plans use the term panel, in-network, preferred, or participating for **providers** in their **network**. See the chart titled Common Medical Event for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	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 in the box titled Services Your Plan Does Not Cover. See your policy or plan document for information about **excluded services**.

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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	$30 copay per visit, Deductible does not apply	20% coinsurance	includes visit, in office lab, xray, injections and office surgical procedures
	Specialist office visit	$60 copay per visit, Deductible does not apply	20% coinsurance	includes visit, in office lab, xray, injections and office surgical procedures
	Preventive care / screening / immunization	0% coinsurance Deductible Waived	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan 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% coinsurance	
	Advanced Imaging (CT/PET scans, MRIs)	0% coinsurance	$500 copay per occurrence, then 20% coinsurance after deductible	Preauthorization is required out-of-network or benefits reduces to 50% of allowed amount.

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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
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 copay, Deductible does not apply Mail Order: $25 copay Deductible does not apply	Retail: $10 copay, Deductible does not apply	Provider 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 Network Pharmacy. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventative medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. 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: $35 copay, Deductible does not apply Mail Order: $87.50 copay Deductible does not apply	Retail: $35 copay, Deductible does not apply	
	Tier 3 - Your Mid-Range Cost Option	Retail: $75 copay, Deductible does not apply Mail Order: $187.50 copay Deductible does not apply	Retail: $75 copay, Deductible does not apply	
	Tier 4 – Your Highest Cost Option	Retail: $150 copay, Deductible does not apply Mail Order: $375 copay Deductible does not apply	Retail: $150 copay, Deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay, then 100% (Deductible and coinsurance do not apply)	20% coinsurance	Preauthorization is required out-of-network or benefits reduces to 50% of allowed amount.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None

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If you need immediate medical attention	Emergency room services	$450 copay per visit, Deductible does not apply	$450 copay per visit, Deductible does not apply	None
	Emergency medical transportation	0% coinsurance	*0% coinsurance	* Network Deductible applies
	Urgent care	$75 copay per visit Deductible does not apply	20% coinsurance	If you receive services in addition to Urgent Care visit, additional copays, deductibles or coinsurance may apply e.g. surgery
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by $500. Preauthorization is required out-of-network or benefits reduces to 50% of allowed amount.
	Physician/surgeon fee	0% coinsurance	20% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$60 copay per visit, Deductible does not apply	20% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 0% coinsurance. Preauthorization is required out-of-network or benefits reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	$500 copay per occurrence, then 0% coinsurance	20% coinsurance	Prior authorization required Penalties for failure to get prior authorization: benefit payment reduced by $500. Preauthorization is required out-of-network or benefits reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	0% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services

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
	Delivery and all inpatient services Professional services	0% coinsurance	20% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include test and services described elsewhere in the SBC (i.e. ultrasound).
	Delivery and all inpatient services Facility services	0% coinsurance	20% coinsurance	$500 per occurrence deductible applies prior to the overall deductible. Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Limited to 60 visits per Calendar Year. Preauthorization is required out-of-network or benefits reduces to 50% of allowed amount.
	Rehabilitation services Occupational, Speech and Physical Therapy	$30 copay per visit, Deductible does not apply	20% 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	$30 copay per visit, Deductible does not apply	20% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of Autism Spectrum Disorder Services for children under the age of 20.
	Skilled nursing care	0% coinsurance	20% 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) Preauthorization is required out-of-network or benefits reduces to 50% of allowed amount.

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
	Durable medical equipment	0% coinsurance	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years. No coverage out-of-network.
	Hospice service	0% coinsurance	20% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by $500. Preauthorization is required out-of-network or benefits reduces to 50% of allowed amount.
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.

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
- Dental care
- 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
- Routine eye care
- 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.)

- Chiropractic care (manipulative care) 20 visits per Calendar year.
- 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.**

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, kwiijigo 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)

The plan's overall deductible	$3,000
Specialist Copay	$60
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,070**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist Copay	$60
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,300**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist Copay	$60
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**