Chris Boies – Chip Schutte – David Weiss - Sharon Keeler – Chuck Bishop

AGENDA
Joint Administrative Services Board
Monday March 22, 2021 11:30 a.m.
Joint Government Center

1. **Call to Order.**

2. **Determination of Quorum.**

3. **Approval of Minutes. (February 22, 2021 Attached).**

4. **Proposed RFP for County/School annual audit.** It is necessary to issue an RFP for the annual audit services. The draft copy of the RFP will be provided at the meeting. In the past, the Director of the Dept. of Joint Administrative Services, a staff member from the Dept. of Joint Administrative Services, and the Treasurer have formed a committee for the purpose of reviewing RFP responses and deciding which vendor to use. The JAS board should discuss whether this method of review and decision should continue for the proposed RFP.

5. **BPA health insurance quote for FY22.** Our current health insurance administrator (Benefit Plan Administrators, aka BPA) has provided a quote for health insurance coverage for the FY22 year. Attached is a spreadsheet showing the FY22 quote amount from BPA, which will provide the same plans and coverage as currently provided to employees. Current health insurance plan documents showing coverage, co-pays, etc are attached For comparison, the BPA *expected* plan costs, as well as the *maximum* plan costs that the County/Schools could incur are shown. Also included on the spreadsheet is the Anthem TLC medical claims history for the previous three fiscal years, showing a pattern of steady medical claims history amounts. This information is provided for the JAS board review and discuss the BPA quote for approval.

6. **RFP for health insurance consultant.** An RFP for an insurance consultant for FY22 will be issued**.** A draft copy of the RFP will be provided at the meeting for review and discussion.

7. **Proposed FY22 Budget Update.**

8. **Next Meeting: April 26, 2021**

Joint Administrative Services Board
February 22, 2021 Regular Meeting 10:00 am

At a regular meeting of the Joint Administrative Services Board held on Monday, February 22, 2021, at 10:00 am in the Meeting Room AB, Berryville Clarke County Government Center, 101 Chalmers Court, 2nd Floor, Berryville, Virginia.

Members Present: Chuck Bishop, Chris Boies, Sharon Keeler, Bev McKay (alternate)

Members Absent: Chip Schutte, David Weiss

Staff Present: Brenda Bennett

Others Present: None

1. Call to Order - Determination of Quorum

   At 10:05 am, Bev McKay (alternate for Vice-Chair David Weiss) called the meeting to order.

2. Determination of Quorum

   Bev McKay determined that a quorum was present.

3. Approval of Minutes

   Chris Boies, seconded by Chuck Bishop, moved to approve the minutes for January 25, 2021, as presented. The motion carried by the following vote:

Chuck Bishop	-	Aye
Chris Boies	-	Aye
Sharon Keeler	-	Aye
Bev McKay		Abstain
Chip Schutte	-	Absent
David Weiss	-	Absent

   - Bev McKay abstained since he was not present at the meeting on January 25, 2021.

4. FY 20 Audit Update

   Brenda Bennett highlight include:

- Spoken with the auditor numerous times about getting the audit complete.
- Auditors have assured her the audit will be ready to present at the March Board of Supervisors meeting.
- Joint Administrative Services has not yet received a completed draft audit but the work to review the draft for the upcoming Board of Supervisors meeting is not expected to take very long.

5. Next Year Audit preparation

Brenda Bennett highlights include:

- The delay in the FY 20 audit is primarily due to the auditors.
- Have pushed them to start the audit work earlier for the FY 21 audit with the site visit in September instead of October, which was what happened last year.
- The auditors have noted that the financial statements provided by JAS needed additional work that typically isn't handled by the auditors.
- Found an independent consultant who can help train Joint Administrative Services staff on what needs to be completed in order for the financial statements to be audit-ready.

By consensus, the Joint Administrative Services Board agreed for this training to occur as long as it was a one-time expenditure and if the work processes needing to occur were well-documented so future staff could use documentation to complete the needed tasks.

6. FY22 Budget Process update

Brenda Bennett highlights include:

- Recapped the Finance Committee meeting held last Wednesday, February 17, 2021, where revenues were reviewed.
- The current outlook is flat compared to the FY 21 revenue projections.
- County departments will present expenditures this Tuesday, February 23, 2021
- Outside agencies will present expenditures on Thursday, February 25, 2021.
- The School Board meets today and will discuss their budget.
- Reported that Tom Judge worked 28 hours to assist in entering salary and benefits data into the budget module.

7. Proposed FY22 JAS Budget Request

Brenda Bennett reviewed the Joint Administrative Services budget line-by-line. Highlighting that the Purchase Services line item was able to absorb the health insurance consultant costs, the Maintenance Service line item was primarily Tyler Technology services, and that the capital request included a new copier.

Chuck Bishop, seconded by Sharon Keeler, moved to approve the proposed budget request as presented. The motion carried by the following vote:

Chuck Bishop	-	Aye
Chris Boies	-	Aye
Sharon Keeler	-	Aye
Bev McKay		Aye
Chip Schutte	-	Absent
David Weiss	-	Absent

8. Health Insurance Update

Brenda Bennett stated that Joint Administrative Services is working with our insurance consultant on obtaining health insurance rates for next year. Adding that the initial rates proposed were higher than expected.

Chuck Bishop responded that an increase to the rates would not be accepted and that a Request for Proposal (RFP) would be issued for insurance services if an increase was proposed.

At 10:40 am, Chris Boies, seconded by Sharon Keeler, moved that the Joint Administrative Services Board enter Closed Session pursuant to §2.2-3711-A6 Discussion of the investment of public funds where competition or bargaining is involved, to discuss the health insurance contract and health insurance consultant contract. The motion carried by the following vote:

Chuck Bishop	-	Aye
Chris Boies	-	Aye
Sharon Keeler	-	Aye
Bev McKay		Aye
Chip Schutte	-	Absent
David Weiss	-	Absent

At 10:50 am, the members of the Board of Supervisors, being assembled within the designated meeting place, with open doors, and in the presence of members of the public and/or the media desiring to attend, Chuck Bishop, seconded by Chris Boies, moved to reconvene in open session. The motion carried as follows:

Chuck Bishop	-	Aye
Chris Boies	-	Aye
Sharon Keeler	-	Aye
Bev McKay		Aye
Chip Schutte	-	Absent

David Weiss - Absent

Chris Boies, seconded by Chuck Bishop, further moved to execute the following Certification of Closed Session:

CERTIFICATION OF CLOSED SESSION

WHEREAS, the Joint Administrative Services Board has convened a closed meeting on the date pursuant to an affirmative recorded vote and in accordance with the provisions of the Virginia Freedom of Information Act; and

WHEREAS, Section 2.2-3700 of the Code of Virginia requires a certification by the Joint Administrative Services Board that such closed meeting was conducted in conformity with Virginia law.

NOW, THEREFORE BE IT RESOLVED, that the Joint Administrative Services Board hereby certifies that, to the best of each members knowledge, (i) only public business matters lawfully exempted from open meeting requirements by Virginia law were discussed in the closed meeting to which the certification resolution applies, and (ii) only such public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Joint Administrative Services Board. The motion was approved by the following roll-call vote:

Chuck Bishop	-	Aye
Chris Boies	-	Aye
Sharon Keeler	-	Aye
Bev McKay		Aye
Chip Schutte	-	Absent
David Weiss	-	Absent

9. Next Meeting

March 22, 2021

10. Adjournment

At 10:50 am, Bev McKay adjourned the meeting.

Minutes Recorded by Chris Boies and Transcribed by Brianna R. Taylor

BENEFIT PLAN ADMINISTRATORS FY22 HEALTH INSURANCE QUOTE

Benefit Plan Administrators quote has three major components

1. Reinsurance Premium (fixed costs - covers claims above the maximum amount the County is responsible for).
2. Administrative Costs (fixed costs - per employee, per month)
3. Expected Claims Costs (variable based on claims submitted)

Benefit Plan Administrators Renewal Quote for FY22		
Maximum Costs for FY22:		
Reinsurance & Administrative Costs	803,238	
Maximum Claims Costs before reinsurance	2,691,235	
	3,494,473	**Maximum Plan Costs**

*The **maximum plan cost** is the maximum amount that Clarke County would need to pay before the reinsurance coverage begins.*

Expected Costs for FY22:		
Reinsurance & Administrative Costs	803,238	
Expected Claims Costs	2,152,988	
	2,956,226	**Expected Plan Costs**

*The **expected plan cost** is what Clarke County can expect to pay based on historical claims and trends.*

	Expected Cost	**Maximum Cost**
Clarke County/Schools estimated FY22 annual funding amount	3,586,270	3,586,270
Less the expected plan costs (shown above)	(2,956,226)	(3,494,473)
BPA expected Claims reserves at the end of FY22	**630,044**	**91,797**
Less Guardian annual premium (not part of BPA plan)	(168,000)	(168,000)
Expected ESI rebate program	100,000	100,000
Total expected additional fund reserve at the end of FY22	**562,044**	**23,797**
Estimated fund reserve at the end of FY21	200,000	200,000
County fund balance designation	500,000	500,000
Total estimated insurance fund at end of FY22	**1,262,044**	**723,797**

Anthem-The Local Choice claims history - shows steady claims history for past 3 years:

Claims History with Anthem TLC*	
FY18	2,134,501
FY19	2,149,130
FY20	2,133,889

The County of Clarke $250 Deductible Group Health Plan

Coverage Period: 1/01/2021-12/31/2021

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

Coverage for: Individual Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.bpatpa.com** or by calling **833-440-7630**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** individual / **$500** family for Network **$500** individual / **$1,000** 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. **$3,000** individual / **$6,000** family for Network **$5,000** individual / **$10,000** family for Out-of-Network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for your health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, Prior Authorization, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.cigna.com** or call **833-440-7630** 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	30% coinsurance AD	None
	Healthiest You	No charge	Not covered	Telephonic Primary Care Services.
	Specialist visit	$35 copay/visit	30% coinsurance AD	None
	Other practitioner office visit	Chiropractic Therapy $35 copay/visit	30% coinsurance AD	Limited to 30 visits per year per member.
	Preventive	No charge	30% coinsurance AD	None
If you have a test	Diagnostic test (x-ray, blood Count work)	Lab/X-Ray - Office 20% coinsurance AD	30% coinsurance AD	None

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		Lab/X-Ray - Outpatient 20% coinsurance AD		
	Imaging (CT/PET scans, MRIs)	20% coinsurance AD	30% 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 (34-day supply) Mail: $20 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document. For more information on Preventative Drugs, visit http://express-scripts.com/2019drugs
	Preferred Brand	Retail: $30 copay/prescription (34-day supply) Mail: $60 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Non-Preferred Brand	Retail: $45 copay/prescription (34-day supply) Mail: $90 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Specialty drugs	Retail: $55 copay/prescription (34-day supply) Mail: $110 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	30% coinsurance AD	None

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	Physician/surgeon fees	$20 copay PCP; $35 copay Specialist/visit	30% coinsurance AD	None
If you need immediate medical attention	Emergency room services	$350 copay/visit	$350 copay/visit	Copayment waived if admitted
	Emergency medical transportation	20% coinsurance AD	20% coinsurance AD	None
	Urgent care	$20 copay PCP; $35 copay Specialist/visit	30% coinsurance AD	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copay/visit	30% coinsurance AD	None
	Physician/surgeon fee	No charge	30% 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 $150 copay/visit	30% coinsurance AD	None
	Mental/Behavioral health inpatient services	$400 copay/visit	30% coinsurance AD	None
	Substance use disorder outpatient services	Office Visit $20 copay/visit Visit – Facility Charges $150 copay/visit	30% coinsurance AD	None
	Substance use disorder inpatient services	$400 copay/visit	30% coinsurance AD	None
If you are pregnant	Prenatal and postnatal care	$20 copay/visit	30% coinsurance AD	Dependent daughters are not covered.
	Delivery and all inpatient services	$400 copay/visit	30% coinsurance AD	Dependent daughters are not covered.
If you need help	Home health care	No charge	30% coinsurance AD	Limited to 90 visits per year.

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recovering or have other special health needs	Rehabilitation services	20% coinsurance AD	30% coinsurance AD	None
	Habilitation services	20% coinsurance AD	30% coinsurance AD	None
	Skilled nursing care	No charge	30% coinsurance AD	Limited to a 180 day/stay.
	Durable medical equipment	20% coinsurance AD	30% coinsurance AD	Covered up to the purchase price
	Hospice service	No charge	30% coinsurance AD	None
If your child needs dental or eye care	Eye exam	$35 copay	Balance after $50	Exam only covered and member may choose any provider. As required by the ACA.
	Glasses	$20 copay for lenses; balance over $100 for frames	Balance after $50 for single lenses; balance over $80 for frames	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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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 • Cosmetic Surgery	• Hearing Aids • Long Term Care • Non-Emergency Care When Traveling Outside the US	• Routine Foot Care • 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.)		
• Bariatric surgery • Chiropractic Care (Limited to 30 visits per benefit period.)	• Infertility Treatment (limited to: diagnostic work to determine diagnosis only) • Private-duty Nursing	• Routine Eye Care • Dental care (adult) – diagnostic and preventive only

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **833-440-7630**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the plan at **833-440-7630**. 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** $5,120
- **Patient pays** $2,420

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	$1,000
Copays	$20
Coinsurance	$1,250
Limits or exclusions	$150
Total	**$2,420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,530
- **Patient pays** 1,870

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	$1,000
Copays	$570
Coinsurance	$220
Limits or exclusions	$80
Total	**$1,870**

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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 **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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The County of Clarke $500 Deductible Group Health Plan

Coverage Period: 1/01/2021-12/31/2021

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

Coverage for: Individual Family | **Plan Type:** PPO

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual / **$1,000** family for Network **$1,000** individual / **$2,000** 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. **$4,000** individual / **$8,000** family for Network **$7,000** individual / **$14,000** family for Out-of-Network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for your health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, Prior Authorization, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.cigna.com** or call **833-440-7630** 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**.
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- **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	$25 copay/visit	30% coinsurance AD	None
	Healthiest You	No charge	Not covered	Telephonic Primary Care Services.
	Specialist visit	$40 copay/visit	30% coinsurance AD	None
	Other practitioner office visit	Chiropractic Therapy $40 copay/visit	30% coinsurance AD	Limited to 30 visits per year per member.
	Preventive	No charge	30% coinsurance AD	None
If you have a test	Diagnostic test (x-ray, blood Count work)	Lab/X-Ray - Office 20% coinsurance AD	30% coinsurance AD	None

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		Lab/X-Ray - Outpatient 20% coinsurance AD		
	Imaging (CT/PET scans, MRIs)	20% coinsurance AD	30% 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 (34-day supply) Mail: $20 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document. For more information on Preventative Drugs, visit http://express-scripts.com/2019drugs
	Preferred Brand	Retail: $30 copay/prescription (34-day supply) Mail: $60 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Non-Preferred Brand	Retail: $45 copay/prescription (34-day supply) Mail: $90 copay/prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Specialty drugs	Retail: $55 copay/prescription (34-day supply) Mail: $110 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	30% coinsurance AD	None

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	Physician/surgeon fees	$25 copay PCP; $40 copay Specialist/visit	30% 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	$25 copay PCP; $40 copay Specialist/visit	30% coinsurance AD	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance AD	30% coinsurance AD	None
	Physician/surgeon fee	No charge	30% coinsurance AD	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit $25 copay/visit Visit – Facility Charges 20% coinsurance AD	30% coinsurance AD	None
	Mental/Behavioral health inpatient services	20% coinsurance AD	30% coinsurance AD	None
	Substance use disorder outpatient services	Office Visit $25 copay/visit Visit – Facility Charges 20% coinsurance AD	30% coinsurance AD	None
	Substance use disorder inpatient services	20% coinsurance AD	30% coinsurance AD	None
If you are pregnant	Prenatal and postnatal care	$25 copay/visit	30% coinsurance AD	Dependent daughters are not covered.
	Delivery and all inpatient services	20% coinsurance AD	30% coinsurance AD	Dependent daughters are not covered.
If you need help	Home health care	No charge	30% coinsurance AD	Limited to 90 visits per year.

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recovering or have other special health needs	Rehabilitation services	20% coinsurance AD	30% coinsurance AD	None
	Habilitation services	20% coinsurance AD	30% coinsurance AD	None
	Skilled nursing care	No charge	30% coinsurance AD	Limited to a 180 day/stay.
	Durable medical equipment	20% coinsurance AD	30% coinsurance AD	Covered up to the purchase price
	Hospice service	No charge	30% coinsurance AD	None
If your child needs dental or eye care	Eye exam	$40 copay	Balance after $50	Exam only covered and member may choose any provider. As required by the ACA.
	Glasses	$20 copay for lenses; balance over $100 for frames	Balance after $50 for single lenses; balance over $80 for frames	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 • Cosmetic Surgery	• Hearing Aids • Long Term Care • Non-Emergency Care When Traveling Outside the US	• Routine Foot Care • 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.)		
• Bariatric surgery • Chiropractic Care (Limited to 30 visits per benefit period.)	• Infertility Treatment (limited to: diagnostic work to determine diagnosis only) • Private-duty Nursing	• Routine Eye Care • Dental care (adult) – diagnostic and preventive only

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **833-440-7630**. 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**.

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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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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** $5,120
- **Patient pays** $2,420

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	$1,000
Copays	$20
Coinsurance	$1,250
Limits or exclusions	$150
Total	**$2,420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,530
- **Patient pays** 1,870

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	$1,000
Copays	$570
Coinsurance	$220
Limits or exclusions	$80
Total	**$1,870**

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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 **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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The County of Clarke $2,800 High Deductible Group Health Plan

Coverage Period: 1/01/2021-12/31/2021

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

Coverage for: Individual Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.bpatpa.com** or by calling **833-440-7630**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,800** individual / **$5,600** family Doesn't apply to Prescription Drugs, In-Network Preventive Care, and Copayments. In-Network Provider and Non- Network Provider deductibles are combined.	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 **833-440-7630** 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 /prescription (34-day supply) Mail: 20% coinsurance AD /prescription (90-day supply)	Not covered	Please refer to Plan Document. For more information on Preventative Drugs, visit http://express-scripts.com/2019drugs
	Preferred Brand	Retail: 20% coinsurance AD /prescription (34-day supply) Mail: 20% coinsurance AD /prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Non-Preferred Brand	Retail: 20% coinsurance AD /prescription (34-day supply) Mail: 20% coinsurance AD /prescription (90-day supply)	Not covered	Please refer to Plan Document.
	Specialty drugs	Retail: 20% coinsurance AD /prescription (34-day supply) Mail: 20% coinsurance AD /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	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 not covered.
	Delivery and all inpatient services	20% coinsurance AD	40% coinsurance AD	Dependent daughters are not covered.
If you need help recovering or	Home health care	20% coinsurance AD	40% coinsurance AD	Limited to 90 visits per year.
	Rehabilitation services	20% coinsurance AD	40% coinsurance AD	None

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have other special health needs	Habilitation services	20% coinsurance AD	40% coinsurance AD	None
	Skilled nursing care	20% coinsurance AD	40% coinsurance AD	Limited to a 180 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	$15 copay	Balance after $50	Exam only covered and member may choose any provider. As required by the ACA.
	Glasses	$20 copay for lenses; balance over $100 for frames	Balance after $50 for single lenses; balance over $80 for frames	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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The County of Clarke $2,800 High 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 • Cosmetic Surgery	• Hearing Aids • Long Term Care • Non-Emergency Care When Traveling Outside the US	• Routine Foot Care • 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.)		
• Bariatric surgery • Chiropractic Care (Limited to 30 visits per benefit period.)	• Infertility Treatment (limited to: diagnostic work to determine diagnosis only) • Private-duty Nursing	• Routine Eye Care • Dental care (adult) – diagnostic and preventive only

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

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Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,120
- **Patient pays** $2,420

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	$1,000
Copays	$20
Coinsurance	$1,250
Limits or exclusions	$150
Total	**$2,420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,530
- **Patient pays** 1,870

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	$1,000
Copays	$570
Coinsurance	$220
Limits or exclusions	$80
Total	**$1,870**

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- 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.
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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?

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Can I use Coverage Examples to compare plans?

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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.

Questions: Call 833-440-7630 or visit us at www.bpatpa.com.
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 833-440-7630 to request a copy.

FY 21 Monthly Health Benefit Rates

Effective 5/16/2020

Source: Joint Administrative Services

A. Plan Rates	Cost	Employer	Employee	Employer FY 21 Share*	Employer FY 20 Share*
				Rounding difference shifts year to year in KA25	
KA 250 Plan Option					
Regular Full Time					
Single	810.00	663.38	146.62	82%	82%
Dual	1,499.00	724.00	775.00	48%	48%
Family	2,187.00	1,056.33	1,130.67	48%	48%
Transportation, Food Service & Other					
Single	810.00	559.74	250.26	69%	69%
Dual	1,499.00	610.90	888.10	41%	41%
Family	2,187.00	891.31	1,295.69	41%	41%
KA 500 Plan Option					
Regular Full Time					
Single	722.00	663.38	58.62	92%	92%
Dual	1,336.00	724.00	612.00	54%	54%
Family	1,949.00	1,056.33	892.67	54%	54%
Transportation, Food Service & Other					
Single	722.00	559.74	162.26	78%	78%
Dual	1,336.00	610.90	725.10	46%	46%
Family	1,949.00	891.31	1,057.69	46%	46%
TLC High Deductible					
Regular Full Time					
Single	592.00	592.00	.00	100%	100%
Dual	1,095.00	672.99	422.01	61%	61%
Family	1,598.00	980.74	617.26	61%	61%
Transportation, Food Service & Other					
Single	592.00	499.52	92.48	84%	84%
Dual	1,095.00	567.85	527.15	52%	52%
Family	1,598.00	827.53	770.47	52%	52%

B. Account Contributions	
Regular Full Time	
TLC Health Savings Account Contribution (single)	71.38
TLC Health Savings Account Contribution (dual)	51.02
TLC Health Savings Account Contribution (family)	75.59
Transportation, Food Service & Other	
TLC Health Savings Account Contribution (single)	60.23
TLC Health Savings Account Contribution (dual)	43.05
TLC Health Savings Account Contribution (family)	63.78

C. Total Employer Cost Per Group Health Member	
Regular Full Time	
Single Health	663.38
Dual Health	724.00
Family Health	1,056.33
TLC High Deductible Single Health & “HSA”	663.38
TLC High Deductible Dual Health & “HSA”	724.00
TLC High Deductible Family Health & “HSA”	1,056.33
Transportation & Food Service	
Single Health	559.74
Dual Health	610.90
Family Health	891.31
TLC Single Health & “HSA”	559.74
TLC Dual Health & “HSA”	610.90
TLC Family Health & “HSA”	891.31

Overall Change
0.00%