



**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.dch.georgia.gov/shbp](http://www.dch.georgia.gov/shbp) or by calling 1-855-641-4862.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$2,000 You/\$3,000 You + Child(ren/Spouse)/ \$4,000 You + Family for In-Network Providers. \$4,000 You/\$6,000 You + Child(ren/Spouse)/ \$8,000 You + Family for Out-of-Network Providers.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, \$5,000 You/\$7,500 You + Child(ren/Spouse)/ \$10,000 You + Family for In-Network Providers. \$10,000 You/\$15,000 You + Child(ren/Spouse)/ \$20,000 You + Family for Out-of-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. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges 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 plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of <u>in-network providers</u> , see <a href="http://www.bcbsga.com/shbp">www.bcbsga.com/shbp</a> or call 1-855-641-4862.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <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 on page 7. See your policy or plan document for additional information about <u>excluded services</u> .

**Questions:** Call 1-855-641-4862 or visit us at [www.bcbsga.com/shbp](http://www.bcbsga.com/shbp). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SHBUniformGlossary.pdf> or call the number above to request a copy.



- **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 In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	20% Coinsurance	40% Coinsurance	There are childhood obesity visit limits.
	Specialist visit	20% Coinsurance	40% Coinsurance	There are childhood obesity visit limits.
	Other practitioner office visit	20% Coinsurance	40% Coinsurance	Chiropractor- Coverage is limited to 20 visits per Benefit Period. Registered Dieticians- there are visit limits. Acupuncturist- Not Covered Prior Authorization is also required for benefits provided for Applied Behavioral Analysis (\$35,000 annual limit).
	Preventive care/screening/immunization	No Charge	Not Covered	No charge for hospital-based Radiologist and Anesthesiologist Services provided by an Out-of-Network Provider at an In-Network Facility and properly coded as Preventive care for Out-of-Network Providers. Covered services must be properly coded as preventive and provided by an in-network provider.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	Lab – Office 20% Coinsurance X-Ray – Office 20% Coinsurance	Lab – Office 40% Coinsurance X-Ray – Office 40% Coinsurance	---None---

**Questions:** Call 1-855-641-4862 or visit us at [www.bcbsga.com/shbp](http://www.bcbsga.com/shbp). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SHBUniformGlossary.pdf> or call the number above to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Prior Authorization may be required.
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available in the Pharmacy SBC	Generic drugs	See Pharmacy SBC.	See Pharmacy SBC.	See Pharmacy SBC. Medical and pharmacy out-of-pocket expenses are combined.
	Preferred brand drugs	See Pharmacy SBC.	See Pharmacy SBC.	See Pharmacy SBC. Medical and pharmacy out-of-pocket expenses are combined.
	Non-preferred brand drugs	See Pharmacy SBC.	See Pharmacy SBC.	See Pharmacy SBC. Medical and pharmacy out-of-pocket expenses are combined.
	Specialty Drugs	See Pharmacy SBC.	See Pharmacy SBC.	See Pharmacy SBC. Medical and pharmacy out-of-pocket expenses are combined.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Prior Authorization may be required.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	Some Providers are Not Covered as assistants at surgery. Prior Authorization may be required.
<b>If you need immediate medical attention</b>	Emergency room services	20% Coinsurance	20% Coinsurance	Prior Authorization required within 1 business day, or as soon as possible, if you are admitted to a non-network Hospital.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	---None---
	Urgent care	20% Coinsurance	40% Coinsurance	---None---
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Prior Authorization may be required.
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	Some Providers are Not Covered as assistants at surgery. Prior Authorization may be required.

**Questions:** Call 1-855-641-4862 or visit us at [www.bcbsga.com/shbp](http://www.bcbsga.com/shbp). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SHBUniformGlossary.pdf> or call the number above to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit 20% Coinsurance Mental/Behavioral Health Facility Visit – Facility Charges 20% Coinsurance	Mental/Behavioral Health Office Visit 40% Coinsurance Mental/Behavioral Health Facility Visit – Facility Charges 40% Coinsurance	Mental/Behavioral Health Office Visit Failure to obtain Prior Authorization may result in non-coverage or reduced benefits. Mental/Behavioral Health Facility Visit – Facility Charges Failure to obtain Prior Authorization may result in non-coverage or reduced benefits.
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	Failure to obtain Prior Authorization may result in non-coverage or reduced benefits.
	Substance use disorder outpatient services	Substance Abuse Office Visit 20% Coinsurance Substance Abuse Facility Visit – Facility Charges 20% Coinsurance	Substance Abuse Office Visit 40% Coinsurance Substance Abuse Facility Visit – Facility Charges 40% Coinsurance	Substance Abuse Office Visit Failure to obtain Prior Authorization may result in non-coverage or reduced benefits. Substance Abuse Facility Visit – Facility Charges Failure to obtain Prior Authorization may result in non-coverage or reduced benefits.
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	Failure to obtain Prior Authorization may result in non-coverage or reduced benefits.
<b>If you are pregnant</b>	Prenatal and postnatal care	20% Coinsurance	40% Coinsurance	Charges for Delivery are part of Prenatal and postnatal care. Prior Authorization may be required.
	Delivery and all inpatient services	20% Coinsurance	40% Coinsurance	Applies to inpatient facility. Other cost shares may apply depending on the services provided. Prior Authorization may be required.

**Questions:** Call 1-855-641-4862 or visit us at [www.bcbsga.com/shbp](http://www.bcbsga.com/shbp). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SHBUniformGlossary.pdf> or call the number above to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<b>If you need help recovering or have other special health needs</b>	Home health care	20% Coinsurance	40% Coinsurance	Prior Authorization may be required.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	There is a benefit maximum of 40 visits per therapy in a benefit year (physical, occupational, speech, cardiac rehab, pulmonary rehab). Physical Therapy-Prior Authorization required for children only after 40 visits. Services provided by a Home Health agency are NOT subject to 40 visit limitations when performed in a home setting. If performed in a home setting the home health care benefit applies.
	Habilitation services	20% Coinsurance	40% Coinsurance	Habilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	20% Coinsurance	Not Covered	Coverage is limited to 120 days per Benefit Period for Facility Services. Prior Authorization may be required.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Prior Authorization required for devices (purchase or cumulative rental) that cost more than \$1,000 per device.
	Hospice service	20% Coinsurance	40% Coinsurance	Prior Authorization may be required. 8 bereavement visits per calendar year.
<b>If your child needs dental or eye care</b>	Eye exam	No Charge	Not Covered	1 routine exam every 24 months.
	Glasses	Not Covered	Not Covered	---None---
	Dental check-up	Not Covered	Not Covered	---None---

**Questions:** Call 1-855-641-4862 or visit us at [www.bcbsga.com/shbp](http://www.bcbsga.com/shbp). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SHBUniformGlossary.pdf> or call the number above to request a copy.

## 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 (except for bariatric pilot program)
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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.)

- Chiropractic care
- Hearing aids limitations may apply
- Non-emergency care when traveling outside the U.S. limitations may apply
- Routine eye care (Adult)

## 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 1-800-610-1863. 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](http://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](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for medical claims under your plan, you may be able to appeal or file a grievance. You should contact Blue Cross Blue Shield of Georgia directly to appeal denial of coverage for medical claims by calling 1-855-641-4862. For appeals related to HRA Account dollars earned in 2015, contact Healthways, Inc. at 1-888-616-6411. For questions about your eligibility, rights, this notice, or assistance, you can contact: the State Health Benefit Plan Call Center at 1-800-610-1863 or access information about eligibility appeals at [www.dch.georgia.gov/shbp](http://www.dch.georgia.gov/shbp).

## 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.**

**Questions:** Call 1-855-641-4862 or visit us at [www.bcbsga.com/shbp](http://www.bcbsga.com/shbp). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SHBUniformGlossary.pdf> or call the number above to request a copy.

### 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 1-855-641-4862.

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

## 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: \$4,450
- Patient pays: \$3,090

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductible	\$2,000
Copays	\$0
Coinsurance	\$1,090
Limits or exclusions	\$0
<b>Total</b>	<b>\$3,090</b>

\*Prescriptions are paid under the pharmacy benefit through Express Scripts, however, your member share is included in this calculation.

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

- Amount owed to providers: \$5,400
- Plan pays: \$4,600
- Patient pays: \$800

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductible	\$800
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$0
<b>Total</b>	<b>\$800</b>

\*Co-insurance for prescriptions, diabetic medical equipment and supplies cost paid at 100% - Disease Management Co-insurance Waiver Program.

## 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 preexisting 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.