

University System of Georgia: Comprehensive Care Plan




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 for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call the number on the back of your ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 397-9267 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers \$1,500 individual / \$4,500 family For out-of-network providers \$4,500 individual / \$13,500 family Does not apply to in-network preventive care.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , Primary Care visit, and <u>Specialist</u> visit for In-Network <u>Providers</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan? Separate out-of-pocket limit for medical and pharmacy.	Medical (Anthem): For in-network providers \$3,300 individual / \$6,600 family For out-of-network providers \$9,900 individual / \$19,800 family Pharmacy (CVS/Caremark): \$2,250 individual/ \$4,500 Two covered members / \$6,750 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Any fourth quarter <u>deductible</u> amounts carried over from previous benefit period,	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Questions: Call the number on the back of your ID card

	Prescription Drugs, Premiums, balance-billing charges, and health care this <u>plan</u> doesn't cover.	
Will you pay less if you use a <u>network provider</u>?	Yes, Blue Open Access POS. Call the number on the back of your ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an out-of- <u>network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an out-of- <u>network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25/visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	-----none-----
	<u>Specialist</u> visit	\$50/visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	-----none-----
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	See contract of coverage for services provided.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	-----none-----
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	-----none-----
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	\$20 copay per prescription for retail \$60 copay per prescription for home delivery	Not covered	Up to a 30 day supply allowed. Mail order and 90 day supply (maintenance) available.
	Tier 2 - Typically Preferred / Brand	20% coinsurance	Not covered	Retail, \$50 minimum and \$125 maximum cost share // Mail order, \$150 minimum and \$375 maximum
	Tier 3 - Typically Non-Preferred	35% coinsurance	Not covered	Retail, \$125 minimum and \$250 maximum cost share // Mail order, \$375 minimum and \$750 maximum

* For more information about limitations and exceptions, see plan or policy document at benefits.usg.edu

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about prescription drug coverage is available by contacting your pharmacy vendor CVS/Caremark Commercial 877-362-3922 SilverScript 866-275-5247	Tier 4 - Typically <u>Specialty</u>	20% coinsurance for generic or preferred brand 35% coinsurance for non-preferred brand	Not Covered	Generic, 20% coinsurance with \$85 maximum // Preferred Brand, 20% coinsurance with \$175 maximum // Non-preferred Brand, 35% coinsurance with \$250 maximum Limited to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	\$300/visit; then 10% <u>coinsurance</u>	\$300/visit then 10% <u>coinsurance</u>	Copay is waived if admitted within 24 hours.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	-----none-----
	<u>Urgent care</u>	\$50/visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> ; balance billing applies	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$25/visit; <u>deductible</u> does not apply Other Outpatient: 10% <u>coinsurance</u>	Office Visit: 40% <u>coinsurance</u> ; balance billing applies Other Outpatient: 40% <u>coinsurance</u> ; balance billing applies	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	Failure to obtain preauthorization may result in non-coverage or reduced coverage.

* For more information about limitations and exceptions, see plan or policy document at benefits.usg.edu

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	\$20/pregnancy first 1 visit; then 10% <u>coinsurance deductible</u> does not apply	40% <u>coinsurance</u> ; balance billing applies	Copay is for the initial office visit to confirm pregnancy.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	-----none-----
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	Physical, Speech, Occupational, and Cardiac therapies are limited to 40 visits/calendar year, combined in- and out-of-network.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	Limited to 30 days/calendar year, combined in- and out-of-network.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	-----none-----
	<u>Hospice services</u>	0% <u>coinsurance</u>	40% <u>coinsurance</u> ; balance billing applies	-----none-----
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Dental care (adult) • Long-term care • Routine foot care unless you have been diagnosed with diabetes. 	<ul style="list-style-type: none"> • Bariatric surgery • Hearing aids (adult) • Private-duty nursing • Weight loss programs 	<ul style="list-style-type: none"> • Cosmetic surgery • Infertility treatment

* For more information about limitations and exceptions, see plan or policy document at benefits.usg.edu

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care 40 visits/benefit period.
- Hearing Aids 1 Item(s)/ear every 48 months for children 18 years of age or under. \$3,000 maximum/hearing aid.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Routine eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, www.oci.ga.gov/ConsumerService/Home.aspx. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105449, Atlanta, GA 30548-5449

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, www.oci.ga.gov/ConsumerService/Home.aspx

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>copayment</u>	\$25

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	\$12,840
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$1,232
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,842

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>copayment</u>	\$25

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	\$7,460
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$125
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$180

Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>copayment</u>	\$25

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	\$2,010
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$136
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$936

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 397-9267

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 397-9267 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 397-9267.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 397-9267:

Bassa (Bàsɔ́ Wùdù): M̄ dyi dyi-diè-dɛ̀ bɛ́ bédé b́á céè-dɛ̀ nià ke dyí ní, ɔ̀ m̀ò nì dyí-bɛ̀dɛ̀in-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè b̄́ kp̄́ dɛ́ m̀ bídǐ-wùdù̀̀m̀ b́ó pídyi. B́é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù̀ ke, d́á (855) 397-9267.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 397-9267 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 397-9267 သို့ ခေါ်ဆိုပါ။

Chinese (中文) : 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 397-9267。

Dinka (Dinka): Na nɔŋ thiëc nē ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wɛr alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (855) 397-9267.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 397-9267.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 397-9267 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 397-9267.

Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 397-9267.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 397-9267.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 397-9267.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 397-9267.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 397-9267 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 397-9267.

Igbo (Igbo): O bụrụ na ị nwere ajụjụ o bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ o bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 397-9267.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 397-9267.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 397-9267.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 397-9267

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 397-9267 にお電話ください。

Language Access Services:

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