Columbus Consolidated Government: Gold Plan

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

Coverage Period: 01/01/2018 – 12/31/2018
Coverage for: Individual + Family | **Plan Type:** POS

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 https://eoc.bcbsga.com/eocdps/aso or by calling (855) 397-9269.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** individual / **$2,000** family for In-Network Providers. Does not apply to Preventive care. **$1,000** individual / **$2,000** family for Out-of-Network Providers. In-Network Providers and Non-Network Providers deductibles are combined and count towards each other.	You must pay all 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 3 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 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; **$6,350** individual / **$12,700** family for In-Network Providers. **$12,700** individual / **$25,400** family for Out-of-Network Providers. Out-of-Network, Out-of-Pocket amounts accumulate towards In-Network Out-of-Pocket limit.	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 health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.

Questions: Call (855) 397-9269 or visit us at www.bcbsga.com
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 397-9269 to request a copy.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 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, POS. For a list of In-Network providers, see www.bcbsga.com or call **(855) 397-9269**.	If you use an in-network doctor or other 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 participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No; you do not 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 6. 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 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 a Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	30% coinsurance	Copay applies to office visit, physician charges, and x-ray and lab charges billed through the office visit.
	Specialist visit	$30 copay per visit	30% coinsurance	Copay applies to office visit, physician charges, and x-ray and lab charges billed through the office visit.
	Other practitioner office visit	Manipulative Therapy 10% coinsurance Acupuncture Not covered	Manipulative Therapy 30% coinsurance Acupuncture Not covered	Manipulative Therapy Coverage for In-Network Providers and Non-Network Providers combined is limited to 30 visits per benefit period. Acupuncture --------none--------
	Preventive care/screening/ immunization	No cost share	30% coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Tier 1 - Typically Generic			
	Tier 2 - Typically Preferred / Brand			
	Tier 3 - Typically Non-Preferred / Specialty Drugs			
	Tier 4 - Typically Specialty Drugs			

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	10% coinsurance	30% coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	$150 copay per visit and 10% coinsurance	$150 copay per visit and 10% coinsurance	Copay waived if admitted. Deductible does not apply.
	Emergency medical transportation	No charges	No charges	--------none--------
	Urgent care	$60 copay per visit	$60 copay per visit	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fee	10% coinsurance	30% coinsurance	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit 10% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 10% coinsurance	Mental/Behavioral Health Office Visit 30% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 30% coinsurance	Deductible does not apply.
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	Deductible does not apply.
	Substance use disorder outpatient services	Substance Use Office Visit 10% coinsurance Substance Use Facility Visit - Facility Charges 10% coinsurance	Substance Use Office Visit 30% coinsurance Substance Use Facility Visit - Facility Charges 30% coinsurance	Deductible does not apply.
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Deductible does not apply.
If you are pregnant	Prenatal and postnatal care	$100 copay per visit	30% coinsurance	--------none--------
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	--------none--------
If you need help recovering or have other special health needs	Home health care	$30 copay per visit	30% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 120 visits per benefit period.
	Rehabilitation services	10% coinsurance	30% coinsurance	Coverage is limited to 30 visits per benefit period for Physical and Occupational

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Out-of-Network Provider	Limitations & Exceptions
				Therapy combined. Coverage is limited to 30 visits per benefit period for Speech Therapy. Apply to In-Network Providers and Non-Network Providers combined.
	Habilitation services	10% coinsurance	30% coinsurance	Habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	10% coinsurance	30% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 30 days limit per benefit period.
	Durable medical equipment	10% coinsurance	30% coinsurance	--------none--------
	Hospice service	No charges	No charges	--------none--------
If your child needs dental or eye care	Eye exam	Not covered	Not covered	--------none--------
	Glasses	Not covered	Not covered	--------none--------
	Dental check-up	Not covered	Not covered	--------none--------

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
- Dental care (adult)
- Infertility treatment
- Long- term care
- Routine eye care (adult)
- 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
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Private-duty nursing

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 (855) 397-9269. 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:

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

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

Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíilkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

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** $5,760
- **Patient pays** $1,780

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	$120
Coinsurance	$510
Limits or exclusions	$150
Total	$1,780

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,350
- **Patient pays** $2,050

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	$860
Coinsurance	$110
Limits or exclusions	$80
Total	$2,050

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**, **co payments**, 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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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) 397-9269

Amharic (አማርኛ)፦ ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 397-9269 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) 397-9269.

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) 397-9269:

Bassa (Bǎsɔ̀ɔ̀ Wùdù): Ǹ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bɛ́ m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (855) 397-9269.

Bengali (বাংলা)**:** যদি এই তথ্য পুস্তিকার বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য কল করুন (855) 397-9269

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 397-9269 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) 397-9269。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (855) 397-9269.

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) 397-9269.

Farsi (فارسي)**:** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 397-9269 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) 397-9269.

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) 397-9269.

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) 397-9269.

Gujarati (□□□□□□□): □□ □ □□□□□□□□ □□□□ □□□□ □□□□□ □□□□□□□ □□□ □□, □□□□□ □□□□ □□□ □□□□ □□□□□□□ □□□ □□□ □□□□□□ □□□□□□□□ □□□□ □□□□□□ □□. □□□□□□□□ □□□□ □□□ □□□□ □□□□, □□□ □□□ (855) 397-9269.

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) 397-9269.

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) 397-9269 ।

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) 397-9269.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 397-9269.

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) 397-9269.

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) 397-9269.

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) 397-9269

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) 397-9269 にお電話ください。

Language Access Services:

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