# GBAIT: HDHP 482:

**Coverage Period: 1/1/17-12/31/17**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **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 www.gabankers.com/GBAIT/gbaithome.asp or by calling 1-877-380-0193.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$4,000** per person/**$8,000** family. Does not apply to in-network preventive care, home health care, skilled nursing and hospice. | 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** person/**$8,000** family medical expenses, **$6,550** per person/**$13,100** family for medical and Rx expenses combined<br>**$10,000** person/**$20,000** family, out-of-network services | 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, pre-authorization penalties, charges over maximum allowed amount, services plan doesn't cover | Even though you pay these expenses, they don't count toward the **out-of-pocket limit.** |
| **Is there an overall annual limit on what the 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.<br>See www.anthem.com for a list of participating providers | 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 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan |

| | | |
|---|---|---|
| **Are there services this plan doesn't cover?** | Yes | Some of the services this plan doesn't cover are listed 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 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 |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | No cost | 30% coinsurance | None |
| | Specialist visit | No cost | 30% coinsurance | None |
| | Other practitioner office visit | No cost | 30% coinsurance for skeletal adjustments | 20 visit per year maximum, combined with physical and occupational therapy |
| | Preventive care/screening/immunization | No cost | 30% coinsurance; | Covered services based on age, gender and other factors. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No cost | 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | No cost | 30% coinsurance | Prior authorization required. |

| 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 |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.magellanrx.com | Generic drugs | After deductible Copay per prescription: $15 retail, $30 mail order | 30% coinsurance plus difference between charge and negotiated rate | Retail covers up to a 30-day supply. Mail order covers up to 90-day supply for generic and preferred brand; 30 days for non-preferred brand drugs.<br><br>Maximum benefit for ulcer drugs: $30; antihistamine: $20<br><br>When generic equivalent available, member pays generic copay plus difference in cost of generic and brand name drug.<br><br>Step therapy required for certain drugs. |
| | Preferred brand drugs | After deductible Copay per prescription: $45 retail, $90 mail order | 30% coinsurance plus difference between charge and negotiated rate | |
| | Non-preferred brand drugs | After deductible Copay per prescription: $70 retail or mail order. | 30% coinsurance plus difference between charge and negotiated rate | |
| | Specialty drugs | After deductible 20% coinsurance up to $500 per prescription per month | 30% coinsurance plus difference between charge and negotiated rate | Not covered unless prior authorization obtained.<br><br>Step therapy required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No cost | 30% coinsurance | Prior authorization required. |
| | Physician/surgeon fees | No cost | 30% coinsurance | Prior authorization required. |
| **If you need immediate medical attention** | Emergency room services | No cost | 30% coinsurance | Not covered if not a medical emergency |
| | Emergency medical transportation | No cost | 30% coinsurance | Not covered if not a medical emergency |
| | Urgent care | No cost | 30% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No cost | 30% coinsurance | Prior authorization required. |
| | Physician/surgeon fee | No cost | 30% coinsurance | Prior authorization required. |

| 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 |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No cost | 30% coinsurance | Some outpatient services require prior authorization. Intensive outpatient and partial hospitalization subject to same limits as home health care. |
| | Mental/Behavioral health inpatient services | No cost | 30% coinsurance | Prior authorization required. Residential treatment facilities subject to same limits as skilled nursing and medical rehab facilities. |
| | Substance use disorder outpatient services | No cost | 30% coinsurance | Some outpatient services require prior authorization. Intensive outpatient and partial hospitalization subject to same limits as home health care. |
| | Substance use disorder inpatient services | No cost | 30% coinsurance | Prior authorization required. Residential treatment facilities subject to same limits as skilled nursing and medical rehab facilities. |
| **If you are pregnant** | Prenatal and postnatal care | No cost | 30% coinsurance | Not covered for dependents other than spouse except as provided in preventive care. |
| | Delivery and all inpatient services | No cost | 30% coinsurance | Not covered for dependents other than spouse except as provided in preventive care. |

| 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 |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | No cost | 30% coinsurance | Maximum visits: 40 per calendar year. Prior authorization required. |
| | Rehabilitation services | No cost | 30% coinsurance | Cardiac and pulmonary rehab requires prior authorization and individual case management. Maximum visits: 20 per calendar year for physical and occupational therapy and skeletal adjustment, combined; 20 visits per year for speech therapy |
| | Habilitation services | No cost | 30% coinsurance | Generally, not covered. Benefits only for certain severe developmental delay |
| | Skilled nursing care | No cost | 30% coinsurance | Maximum days: 60 per calendar year. Prior authorization required. |
| | Durable medical equipment | No cost | 30% coinsurance | Prior authorization required. |
| | Hospice service | No cost | 30% coinsurance | Prior authorization required. |
| **If your child needs dental or eye care** | Eye exam | Not covered | Not covered | Annual screening covered under preventive care. |
| | Glasses | Not covered | Not covered | |
| | Dental check-up | Not covered | Not covered | |

## 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 (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. unless prior authorization obtained
- 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, limited to 20 visits per year combined with physical and occupational therapy
- Private-duty nursing when ICU or CCU not available

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State law 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 GBA Insurance Trust at 404-522-1501. 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: Paragon Benefits, Inc. at 1-800-277-9218 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-380-0193.

# 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** $3,540
- **Patient pays** $4,000

**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 | $4,000 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$4,000** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,400
- **Patient pays** $4,000

**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 | $4,000 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$4,000** |

# 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.