SGMC HEALTH

SGMC Health Employee Health Plan

Coverage for: Individual, Individual + Spouse, Individual + Child(ren), Family | Plan Type: PPO

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, www.myLuminareHealth.com. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-990-9058 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For SGMC Health providers: $500/individual or $1,000/family per calendar year. For preferred providers: $2,000/individual or $4,000/family per calendar year. For non-preferred providers: $7,000/individual or $14,000/family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription drugs (subject to specific deductible only, see below), emergency treatment in an emergency room, SGMC Health inpatient and outpatient hospital, SGMC Health diagnostic tests and outpatient surgery, and the following services by an SGMC Health or preferred provider: preventive care, inpatient and office visits, imaging tests, rehabilitation services, urgent care, outpatient surgery (facility) and routine maternity services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50/individual or $100/family for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For SGMC Health providers $6,600/individual or $13,200/family, per calendar year. For preferred providers: $8,550 / individual or $17,100/family per calendar year. Nonpreferred providers: Unlimited.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Non-preferred provider deductible and coinsurance, penalties for failure to obtain preauthorization for services, premiums, balance-billing 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	See www.bcbsga.com or call 1-800-810-2583 for a list of preferred providers.	You pay the least if you use a provider in SGMC Health. You pay more if you use a provider in Blue Cross Anthem GA network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		SGMC Provider (You will pay the least)	Anthem GA Preferred Provider (You will pay more)	Nonpreferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/office visit deductible does not apply	$30 copay/office visit deductible does not apply	50% coinsurance	SGMC Health Urgent Care Center:$20 copay/visit deductible does not apply
	Specialist visit	$60 copay/visit deductible does not apply	$60 copay/visit deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay then 10% coinsurance deductible does not apply	20% coinsurance	50% coinsurance	Benefit includes EKGs.
	Imaging (CT/PET scans, MRIs)	$200 copay then 10% coinsurance deductible does not apply	$400 copay then 20% coinsurance deductible does not apply	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SGMC Provider (You will pay the least)	Anthem GA Preferred Provider (You will pay more)	Nonpreferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or call 1-866-644-7527.	Generic drugs	$10 copay for 34-day supply retail (60-day for maintenance drugs) and for Walmart Drug Listing $4 copay for 34-day supply and $10 copay for 90-day supply of maintenance drugs. Prescription deductible applies. Plan deductible does not apply.	$15 copay for 34-day supply retail. Prescription deductible applies. Plan deductible does not apply.	Not Covered	Copay and coinsurance do not apply to preventive drugs required by the Affordable Care Act.
	Preferred brand drugs	20% with minimum $25 copay and maximum $100 copay for 34-day supply retail or 60-day for maintenance drugs. Prescription deductible applies. Plan deductible does not apply.	25% with minimum $30 copay and maximum $100 copay for 34-day supply retail. Prescription deductible applies. Plan deductible does not apply.	Not Covered	
	Non-preferred brand drugs	20% with minimum $40 copay and maximum $100 copay for 34-day supply retail or 60-day for maintenance drugs. Prescription deductible applies. Plan deductible does not apply.	25% with minimum $45 and maximum $100 copay for 34-day supply retail. Prescription deductible applies. Plan deductible does not apply.	Not Covered	
	Specialty drugs	20% coinsurance up to a maximum of $200. Prescription deductible applies. Plan deductible does not apply.	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay then 10% coinsurance deductible does not apply	$1,000 copay then 20% coinsurance deductible does not apply	50% coinsurance	Preauthorization is required for some surgeries. If you don't get preauthorization, benefits will be denied.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SGMC Provider (You will pay the least)	Anthem GA Preferred Provider (You will pay more)	Nonpreferred Provider (You will pay the most)	
If you have outpatient surgery (continued)	Physician/surgeon fees	$100 copay then 20% coinsurance deductible does not apply	Office $100 copay then 20% coinsurance deductible does not apply; Other $100 copay then 20% coinsurance (deductible does not apply if at an SGMC Health facility)	Office Not Covered; Other 50% coinsurance	None
If you need immediate medical attention	Emergency room care	Emergency $250 copay/visit deductible does not apply; Non-emergency $500 copay/visit deductible does not apply	Emergency $250 copay/visit deductible does not apply; Non-emergency $500 copay/visit deductible does not apply	Emergency SGMC Health provider benefit applies; Non-emergency $500 copay/visit deductible does not apply	Copay waived if admitted within 24 hours.
	Emergency medical transportation	10% coinsurance	10% coinsurance	SGMC Health provider benefit applies.	None
	Urgent care	$30 copay/ visit deductible does not apply	$75 copay/visit deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/day (limit 5 copays per confinement) then 10% coinsurance deductible does not apply	20% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Physician/surgeon fees	20% coinsurance deductible does not apply	20% coinsurance deductible does not apply if at an SGMC Health facility	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit or clinic visit deductible does not apply; 10% coinsurance for other outpatient services	$15 copay/office visit or clinic visit deductible does not apply; 20% coinsurance for other outpatient services	50% coinsurance	Preauthorization is required for some services. If you don't get preauthorization, benefits will be denied.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SGMC Provider (You will pay the least)	Anthem GA Preferred Provider (You will pay more)	Nonpreferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services (continued)	Inpatient services	Facility $100 copay/day (limit 5 copays per confinement) then 10% coinsurance deductible does not apply; Physician 20% coinsurance deductible does not apply	Facility 20% coinsurance; Physician 20% coinsurance (deductible does not apply if at an SGMC Health facility)	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you are pregnant	Office visits	$30/$60 copay/ office visit deductible does not apply	$30/$60 copay/ office visit deductible does not apply	50% coinsurance	Dependent daughters are not covered for this benefit. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance deductible does not apply	20% coinsurance (deductible does not apply if at an SGMC Health facility)	50% coinsurance	
	Childbirth/delivery facility services	$300 copay then 10% coinsurance deductible does not apply	$1,000 copay then 20% coinsurance deductible does not apply	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	50% coinsurance	120 visits/calendar year. Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Rehabilitation services	100% after $30 copay deductible waived	100% after $30 copay deductible waived	50% coinsurance	Medical necessity review required for more than 30 visits per calendar year.
	Habilitation services	100% after $30 copay deductible waived	100% after $30 copay deductible waived	50% coinsurance	Birth through age 18. Medical necessity review required for more than 20 visits per calendar year.
	Skilled nursing care	10% coinsurance	20% coinsurance	50% coinsurance	90 visits/calendar year. Preauthorization is required. If you don't get preauthorization, benefits will be denied.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SGMC Provider (You will pay the least)	Anthem GA Preferred Provider (You will pay more)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Durable medical equipment	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required for equipment >$500. If you don't get preauthorization, benefits will be denied.
	Hospice services	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required for inpatient hospice. If you don't get preauthorization, benefits will be denied.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Routine vision services required by the Affordable Care Act are covered under the preventive care benefit.
	Children's glasses	Not covered	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Hearing aids (children 18 years or younger, limit one per ear, up to $3,000, every 48 months)
- Non-emergency care when traveling outside the U.S.

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 on how 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: Contact Luminare Health Benefits, Inc. at 1-800-990-9058 or visit us at www.myLuminareHealth.com.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-990-9058.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-990-9058.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-990-9058.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-990-9058.

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 plan's overall deductible	**$500**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$500
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	**$500**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$550
Copayments	$600
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,870**

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

The plan's overall deductible	**$500**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,170**

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

* For more information about limitations and exceptions, see the plan or policy document at www.myLuminareHealth.com.