Health Care Basics:

Choosing the Best Option for Your Health

"Creating A More Educated Georgia"

2013

Medical options for plan year 2013

The University System of Georgia's Plan Year 2013 Open Enrollment will begin October 15, 2012 and will end November 9, 2012.

The Board of Regents will offer the following health care options:

- Blue Choice HMO
- Kaiser Permanente HMO
- HSA Open Access POS
- Open Access POS

Please take the time to carefully weigh the plans available, and choose the option that's best for you. If you have questions, or need help, please contact your campus Human Resources office.

The following benefit changes will take effect January 1, 2013:

- The BCBSGa and Kaiser HMO plans are open for new enrollments
- Some of the co-pays are increasing in the BCBSGa and Kaiser HMO plans
- Increase in Premiums
- New women's Preventive Benefits. Covered at 100% in all of the University System of Georgia health care plans:
  - **Well-Women Visits**
  - **Screening for Gestational Diabetes**
  - **Human Papillomavirus (HPV) testing**
  - **Counseling for sexually transmitted infections**
  - **Counseling and screening for human immune-deficiency virus**
  - **Contraceptive methods and counseling**
  - **Breastfeeding support, supplies, and counseling**
  - **Screening and counseling for interpersonal and domestic violence**
- HSA employer contribution match continues in 2013
  - Single – $375.00
  - Family – $750.00

  HSA contribution limits for 2013 are as follows:

  Single: $3,250 (or $2,875 net of employer match)

  Family: $6,450 (or $5,700 net of employer match)

  Catch-up: $1,000 for employees 55 or older
- Minor changes to the Open Access POS (ESI) prescription plan (see page 22).

Be Healthy: Wellness and Health Care Support

The University System of Georgia cares about you and your family's health! That's why we have partnered with BCBSGa and Kaiser to provide wellness benefits and health care support when you need it. Take advantage of these programs to keep you and your family healthy throughout the year:

- Preventive exams – covered under the health care plans at 100%! Take action and proactively manage your health before a serious medical condition occurs.
- On-line health risk assessment – measures how well you are doing managing your health, on-line health and wellness information, discounts on health-related products and alternative medicine therapies available on-line at www.bcbsga.com/bor or at www.kp.org
- 24/7 NurseLine BCBSGa: 800-785-0006 Kaiser: 404-365-0966 (Metro Atlanta) 800-611-1811 (outside Atlanta)
- Health support programs for employees with on-going conditions or for those coping with a serious illness. These programs provide you with information about your condition and help you keep on schedule with doctors visits and medications.

For more information about the Health Support programs, see pages 20-21 and/or call BCBSGa at 1-800-785-0006 or Kaiser at 404-261-2590 in Atlanta or 888-865-5813 outside of Atlanta.

Comparison guide

To assist you in making your health care plan decisions for Plan Year 2013, we have included a brief comparison of all of your health plan options in this booklet. In addition, premium rates for the 2013 offerings are outlined in this booklet. The BlueChoice HMO and Kaiser Permanente HMO health care plan options are deemed to be managed health care plans. Please be reminded of the 2002 Georgia statute, which states that members who participate in a managed health care plan are hereby advised of the following limitation: "For reimbursement, your health care plan may restrict the choice of who may treat you or your family, and where you may be treated."

Thank you for your service to the University System of Georgia. Please continue your long-standing practice of using your health care plan benefits responsibly. We are pleased to share the following information that affects a critically important aspect of everyone's life – his or her health.

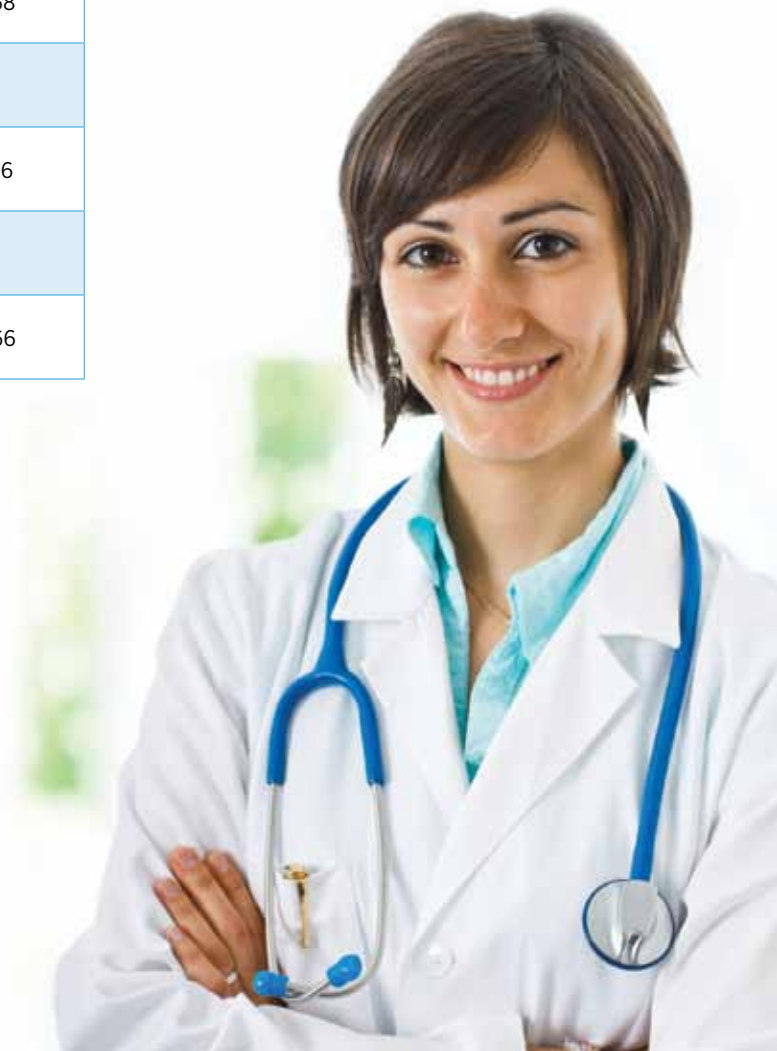
Pharmacy benefits for Open Access POS Plan

The Board of Regents uses Express Scripts to provide the Pharmacy Benefit for the Open Access POS plan and to manage a Coverage Review Program. This program helps manage costs while ensuring you and your family have access to the medications you need to stay healthy. Information regarding this program may be found on page 22 of the Health Benefits Comparison Guide.

2013 Premium Rates for Active Employees

	Open Access POS	HSA Open Access POS	BlueChoice HMO	Kaiser HMO	Metlife Dental
Employee Only	$180.00	$47.00	$142.00	$133.00	$30.84
Employee + Child	$323.00	$83.00	$255.00	$239.00	$58.58
Employee + Spouse	$377.00	$96.00	$297.00	$278.00	$61.66
Family	$521.00	$132.00	$410.00	$384.00	$98.66

A tobacco surcharge of $50 will be added to your monthly premium if you use tobacco products.
The $50 Tobacco Surcharge applies to any tobacco use.



2013 Premium Rates for Retired Employees

	Open Access POS			HSA OA POS	Kaiser Senior Advantage*
	Enrolled	Not Enrolled	One Enrolled		*Medicare enrollment is required in this plan
Retiree (Medicare Eligible)					
Employee	$101.00	$201.00		$47.00	$114.00
Employer	$237.00	$489.00		$269.00	$266.10
Total Rates	$338.00	$690.00		$316.00	$380.10
Retiree w/Spouse (both Medicare Eligible)					
Employee	$203.00	$403.00	$303.00	$96.00	$228.00
Employer	$473.00	$979.00	$715.00	$545.00	$532.20
Total Rates	$676.00	$1,382.00	$1,018.00	$641.00	$760.20
Retiree (Medicare Eligible) w/Child					
Employee	$245.00	$345.00		$83.00	$246.00
Employer	$572.00	$824.00		$469.00	$572.98
Total Rates	$817.00	$1,169.00		$552.00	$818.98
Retiree (Non-Medicare Eligible) w/Medicare Eligible Spouse					
Employee	$281.00	$381.00		$96.00	$246.00
Employer	$656.00	$908.00		$545.00	$572.98
Total Rates	$937.00	$1,289.00		$641.00	$818.98
Retiree (Medicare Eligible) w/ Non-Medicare Eligible Spouse					
Employee	$299.00	$399.00		$96.00	$246.00
Employer	$698.00	$950.00		$545.00	$572.98
Total Rates	$997.00	$1,349.00		$641.00	$818.98

A tobacco surcharge of $50 will be added to your monthly premium if you use tobacco products. The $50 Tobacco Surcharge applies to any tobacco use.

*Note: Retirees and/or Spouses who are not eligible for Medicare will pay the active rates. Retirees and Spouses reaching age 65 have the option to enroll in Medicare Part B or pay the full cost of insurance shown in the not enrolled rates column.

2013 Premium Rates for Retired Employees (continued)

	Open Access POS			HSA OA POS	Kaiser Senior Advantage*
	Enrolled	Not Enrolled	One Enrolled		*Medicare enrollment is required in this plan
Retiree (Non-Medicare Eligible) w/Medicare Eligible Spouse & Family					
Employee	$435.00	$535.00		$132.00	$371.00
Employer	$1,014.00	$1,266.00		$745.00	$864.92
Total Rates	$1,449.00	$1,801.00		$877.00	$1,235.92
Retiree (Medicare Eligible) w/Non-Medicare Eligible Spouse & Family					
Employee	$443.00	$543.00		$132.00	$371.00
Employer	$1,033.00	$1,285.00		$745.00	$864.92
Total Rates	$1,476.00	$1,828.00		$877.00	$1,235.92
Retiree w/Spouse (Both Medicare Eligible) w/ Family					
Employee	$347.00	$547.00	$447.00	$132.00	$360.00
Employer	$809.00	$1,315.00	$1,051.00	$745.00	$839.08
Total Rates	$1,156.00	$1,862.00	$1,498.00	$877.00	$1,199.08

A tobacco surcharge of $50 will be added to your monthly premium if you use tobacco products. The $50 Tobacco Surcharge applies to any tobacco use.

*Note: Retirees and/or Spouses who are not eligible for Medicare will pay the active rates. Retirees and Spouses reaching age 65 have the option to enroll in Medicare Part B or pay the full cost of insurance shown in the not enrolled rates column.

I'm turning 65 this year and still actively working. What do I need to do?

If you're turning 65 this year you'll be getting a Medicare Enrollment kit giving you the option to enroll in Medicare Parts A, B, C as well as Medicare Part D. You'll be getting the kit 60 to 90 days before your birthday.

Please read the Medicare materials carefully. It helps to know all you can when you make a decision about enrolling in Medicare.

If you're an active employee and you get your health insurance through your institution, this coverage will be your primary insurance. Medicare will be your secondary coverage.

Your coverage as an active employee is considered Credible Coverage for Medicare Parts B and D. As long as you're enrolled in health coverage through your institution as an active employee, you won't be penalized if you put off enrolling in Medicare Parts B and D until your retirement.

For more information, visit the Medicare website at: http://www.medicare.gov or contact your institution's human resources office.

2013 Key Benefit Comparisons by Plan

Key Benefit	HSA Open Access POS In-Network	HSA Open Access POS Out-of-Network	Open Access POS In-Network	Open Access POS Out-of-Network
Description of Plans	Major Medical coverage, including diagnosis and/or treatment of illness injury or medical conditions. Benefits include physician, hospital, surgical, ConditionCare, pharmacy benefit management, behavorial health (mental health/substance abuse), and transplant services. Members who elect to use the services of out-of-network doctors and hospitals will receive lower level of benefit coverage and are subject to balance billing. Members are also responsible for all costs over the plan visit limits. All health care and prescriptions covered under the plan are subject to deductible (with the exception of Preventive care). This is a Health Savings Account qualified plan. You may open an HSA when enrolled in this plan.		Major Medical coverage, including diagnosis and/or treatment of illness injury or medical conditions. Benefits include physician, hospital, surgical, ConditionCare, pharmacy benefit management, behavorial health (mental health/substance abuse), and transplant services. Members who elect to use the services of out-of-network doctors and hospitals will receive lower level of benefit coverage and are subject to balance billing.	
Lifetime Maximum	Unlimited		Unlimited	
Maximum Annual Deductible	$1,500 Individual (single coverage) $3,000 Family (2 or more covered members)		$300 Individual $900 Family (3 or more covered members)	$400 Individual $1,200 Family (3 or more covered members)
	Deductible is combined for in- and out-of-network Benefits, including pharmacy. For a family contract, all eligible members share a combined family deductible. Family is considered two or more members and the entire deductible must be satisfied before co-insurance kicks in for services subject to deductible and co-insurance. $1,500 Individual $3,000 Family (2 or more covered members)		Members who use both in-network (including BlueCard National and Worldwide Network) providers and out-of-network providers will be responsible for two separate deductibles and for two separate maximum out-of-pocket limits. The in-network deductible is $300 per individual and once an individual meets this deductible, their claims will pay at 90%. If there are 3 or more members in a family, the maximum a family will have to meet towards the in-network deductible is $900. This can be met in any combination. However, the family deductible does not have to be satisfied for a person meeting their individual deductible of $300 to have claims paid at 90%.	
Maximum Annual Out-of-Pocket Limit	$3,000 Individual (single coverage) $6,000 Family (2 or more covered members)	$6,000 Individual (single coverage) $12,000 Family (2 or more covered members)	$1,000 Individual $2,000 Family (3 or more covered members)	$2,000 Individual $4,000 Family (3 or more covered members)
	Includes the Maximum Annual Deductible. In- and out-of-network co-insurance amounts accumulated remain separate – they do not cross accumulate like the deductible.		Member copayments for physician office visits, for emergency room services, and/or for prescription drugs do not apply toward the annual deductible(s) or toward the maximum annual out-of-pocket limit(s)	
Pre-existing Conditions	Not Applicable			
Out-of-State/Out-of-Country coverage	In-network coverage out-of-state utilizes the BlueCard National network and out-of-country uses BlueCard WorldWide			
PCP/Referral Required	No		No	

Annual deductibles, annual maximum out-of-pocket limits, annual visit limitations, are based on a January 1 – December 31 plan year.

January 1, 2013

BlueChoice HMO	Kaiser HMO	Kaiser Senior Advantage 65+
A Health Maintenance Organization (HMO) is comprised of a network of physicians, hospitals, and other health care providers. HMO plan participants must use network providers to receive benefit coverage, except in an emergency. Enrolled employees/ eligible retirees and covered family members will be required to select a primary care physician (PCP) from the HMO network. The selected PCP will coordinate the medical services for a member and will issue a referral to a network specialist for specialty care as needed. PCPs include general practitioners, family medicine practioners, internal medicine practitioners, and pediatricians.	Kaiser Permanente is uniquely designed with everything under one roof. Many of our locations include pharmacy, lab, and x-ray services so you can do more and drive less. Our HMO allows you to choose from 29 Kaiser Permanente facilities and more than 500 doctors and other providers throughout metro Atlanta. You can also get care at 13 affiliated hospitals and approximately 30 affiliated urgent care locations in the area. Emergency care coverage is available anywhere in the world.	Kaiser Permanente's senior advantage program is a Medicare Advantage Part D plan. You must have Medicare part A and B to enroll. Participating retirees must reside within the Medicare Advantage service area to be eligible for benefit coverage. The senior advantage Service area include the following counties: Barrow, Bartow, Butts, Cherokee, Clayton, Cobb, Coweta, Dekalb Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale, Spalding and Walton.
Unlimited	Unlimited	Unlimited
None	None	None
N/A	N/A	N/A
None	None	$2,000 Single
N/A	N/A	$6,000 Family
Not Applicable		
Emergency Care only	Emergency Care only	
Yes	Yes	

2013 Key Benefit Comparisons by Plan (continued)

Key Benefit	HSA Open Access POS In-Network	HSA Open Access POS Out-of-Network	Open Access POS In-Network	Open Access POS Out-of-Network
Physician Services Provided In An Office Setting				
Primary Care Provider/Office Visit	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	100% of network rate after $20 copayment per visit; not subject to deductible The $20 copayment applies to the office visit service only	60% of network rate; subject to deductible and balance billing
Wellness/Preventive Care	Paid at 100% of network rate; not subject to deductible	Paid at 70% of network rate; not subject to deductible; subject to balance billing	Paid at 100% of network rate; not subject to deductible	Not Covered Non-covered charges do not apply to annual deductible or annual out-of-pocket maximum
Routine Eye-Exam w/Opthamologist or Optometrist	Paid at 100% of network rate; not subject to deductible	Paid at 70% of network rate; not subject to deductible; subject to balance billing	Paid at 100% of network rate; not subject to deductible	Not Covered Non-covered charges do not apply to annual deductible or annual out-of-pocket maximum
Specialist Office-Visit	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	100% of network rate after $20 copayment per visit; not subject to deductible The $20 copayment applies to the office visit service only	60% of network rate; subject to deductible and balance billing
Laboratory Services	90% of network rate; subject to deductible In-network lab is LabCorp	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible In-network lab is LabCorp	60% of network rate; subject to deductible and balance billing
Maternity Care	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate after an initial visit copayment of $20; not subject to deductible There will be no copayments charged for subsequent visits	60% of network rate; subject to deductible and balance billing
Surgery in-office	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Allergy Testing	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Allergy Shots & Serum	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	100% of network rate; not subject to deductible If a physician is seen, the visit is treated as an office visit and is subject to the $20 copayment per visit	60% of network rate; subject to deductible and balance billing

January 1, 2013

BlueChoice HMO	Kaiser HMO	Kaiser Senior Advantage 65+
Plan pays 100% after $15 copayment	Plan pays 100% after $15 copayment	Plan pays 100% after $15 copayment
Plan pays 100%	Plan pays 100%	Plan pays 100%
Not covered	Plan pays 100% after $25 copayment to Optometrist	Plan pays 100% after $15 copayment to Optometrist
Plan pays 100% after $25 copayment	Plan pays 100% after $25 copayment	Plan pays 100% after $15 copayment
Plan pays 100% In-network lab is LabCorp	Plan pays 100%	Plan pays 100%
All physician charges related to prenatal, delivery and postpartum care are covered at 100% after an initial copayment of $25 at first office visit	Plan pays 100%	Plan pays 100%
Plan pays 100% after $25 copayment	Plan pays 100% after $25 copayment	Plan pays 100% after $15 copayment
Plan pays 100% after $25 copayment	Plan pays 100% after $25 copayment	Plan pays 100% after $15 copayment
Plan pays 100% after $25 copayment	Plan pays 100% after $25 copayment; $0 copayment for serum	Plan pays 100% after $15 copayment; $0 copayment for serum

2013 Key Benefit Comparisons by Plan (continued)

Key Benefit	HSA Open Access POS In-Network	HSA Open Access POS Out-of-Network	Open Access POS In-Network	Open Access POS Out-of-Network
Inpatient Hospital Services - Pre-certification required except for Emergency				
Physician Services Physician services may include surgery, anesthesiology, pathology, radiology and/or maternity care/delivery	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Hospital Facility Services In-patient care (includes in-patient short-term rehabilitation services)	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible limited to semi-private room	60% of network rate; subject to deductible and balance billing
Maternity Delivery	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Laboratory Services	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Skilled Nursing Facility	90% of network rate; subject to deductible 30 days per calendar year combined in- and-out-of-network	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible 30-day calendar year maximum combined in- and out-of-network	60% of network rate; subject to deductible and balance billing
Hospice Care	100% of network rate; subject to deductible	100% of network rate; subject to deductible and balance billing	100% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Outpatient Hospital/Facility Services - Pre-certification required except for Emergency				
Physician Services Physician services may include surgery, anesthesiology, pathology, radiology and/or maternity care/delivery	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Hospital Facility Services including out-patient surgery and diagnostic testing	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Care in Hospital Emergency Room	90% of network rate; subject to deductible	90% of network rate; subject to deductible and balance billing	90% of network rate after a $50 copayment per visit; subject to deductible copayment is waived if admitted within 24 hours	90% of network rate after a $50 copayment per visit; subject to deductible copayment is waived if admitted within 24 hours
Ambulance Services Land or air ambulance for medically necessary emergency transportation only	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible; subject to balance billing for non-participating providers of ambulance services	
Urgent Care Services	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing

January 1, 2013

BlueChoice HMO	Kaiser HMO	Kaiser Senior Advantage 65+
Plan pays 100%	Plan pays 100%	Plan pays 100%
Plan pays 100% after $250 copayment	Plan pays 100% after $250 copayment	Plan pays 100% after $200 copayment
Plan pays 100% after $250 copayment	Plan pays 100% after $250 copayment	Plan pays 100% after $200 copayment
Plan pays 100%	Plan pays 100%	Plan pays 100%
Plan pays 100% 30-day limit per calendar year	Plan pays 100%; 60-day limit per calendar year	Plan pays 100%; 100-day limit per calendar year
Plan pays 100%	Plan pays 100%	Plan pays 100%
Plan pays 100%	Plan pays 100%	Plan pays 100%
Plan pays 100% after $100 copayment	Plan pays 100% after $100 copayment	Plan pays 100% after $50 copayment
Plan pays 100% after $150 copayment	Plan pays 100% after $150 copayment	Plan pays 100% after $50 copayment
Plan pays 100%	Plan pays 100% after $75 copayment per trip	Plan pays 100% after $75 copayment per trip
Plan pays 100% after $30 copayment	Plan pays 100% after $30 copayment	Plan pays 100% after $30 copayment

2013 Key Benefit Comparisons by Plan (continued)

Key Benefit	HSA Open Access POS In-Network	HSA Open Access POS Out-of-Network	Open Access POS In-Network	Open Access POS Out-of-Network
Other Services				
Home Health	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Home Nursing Care	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Durable Medical Equipment	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Cochlear Implants	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Chiropractic Care	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Physical Therapy **Speech Therapy** **Occupational Therapy** **Cardiac Therapy**	Physical, occupational, athletic trainers and chiropractic care combined 20 visits Speech therapy 20 visits per calendar year Respiratory therapy 30 visits Note: In- and out-of-network visit limits are combined per calendar year		Chiropractic limited to a 40-visit limit per plan year combined in- and out-of-network Physical, speech, occupational and cardiac therapies are limited to a 40-visit limit per plan year combined in- and out-of-network	

January 1, 2013

BlueChoice HMO	Kaiser HMO	Kaiser Senior Advantage 65+
Plan pays 100% 120 visits per calendar year	Plan pays 100%; 120 visits per calendar year	Plan pays 100%; 120 visits per calendar year
Plan pays 100%	Contact plan for details	Contact plan for details
Plan pays 100%	Plan pays 50%	Plan pays 80%
Covered if deemed medically necessary; pre-authorization required	Covered if deemed medically necessary; pre-authorization required	Covered if deemed medically necessary; pre-authorization required
Plan pays 100% after $25 copayment 20 visits per calendar year	Plan pays 100% after $25 copayment; 20 visits per calendar year	Plan pays 100% after $15 copayment; 20 visits per calendar year
Plan pays 100% after $25 copayment 30-visit limit for Speech therapy and a 40-visit limit for Physical and Occupational therapy	Plan pays 100% after $25 copayment; 20-visit limit combined with Physical and Occupational therapy. Speech therapy 20-visit limit per year	Plan pays 100% after $15 copayment; 20 visits per calendar year per each therapy.

2013 Key Benefit Comparisons by Plan (continued)

Key Benefit	HSA Open Access POS In-Network	HSA Open Access POS Out-of-Network	Open Access POS In-Network	Open Access POS Out-of-Network
Behavorial Health & Substance Abuse				
Inpatient	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; subject to deductible	60% of network rate; subject to deductible and balance billing
Partial Hospitalization	Not covered		90% of network rate; not subject to deductible	60% of network rate; subject to deductible and balance billing
Outpatient	90% of network rate; subject to deductible	70% of network rate; subject to deductible and balance billing	90% of network rate; not subject to deductible	60% of network rate; subject to deductible and balance billing
Intensive Outpatient	Not covered		90% of network rate; not subject to deductible	60% of network rate; subject to deductible and balance billing
Pharmacy Services				
Prescription Drugs	90% of network rate; subject to deductible 30-day supply limit (90-day supply limit for maintenance drugs) not subject to a formulary but some medications may require pre-authorization or step-therapy. Mail order coverage not available.		See Page 22	

How to locate Georgia providers for the BCBSGa HSA Open Access POS and Open Access POS plans

1. Go to **bcbsga.com/bor**
2. Click on **Find a Doctor**
3. Click on **Georgia Providers for Individual Plans and Group Plans** (through your employer)
4. Complete Steps 2 and 3
5. In Step 4, Plan Type, choose **POS** from the drop down
6. In Step 5, Plan Name, choose **Blue Open Access POS** from the drop down

January 1, 2013

BlueChoice HMO	Kaiser HMO	Kaiser Senior Advantage 65+
Plan pays 100%	Plan pays 100% after $250 copayment	Plan pays 100% after $200 copayment
Not covered	Contact plan for details	Contact plan for details
Plan pays 100%	Plan pays 100% after $15 copayment	Plan pays 100% after $15 copayment
Not covered	Contact plan for details	Contact plan for details
$10 copayment for generic $25 copayment for name brand (up to a 30-day supply). Mail order and 90-day supply not available.	$10 copay generic at Kaiser facility/$20 copay generic at network pharmacies (for 1st fill only). $25 brand at Kaiser facility/$35 brand at network pharmacies (for 1st fill only). 2x copay for 90-day supply via mail order at Kaiser facility.	$10 copay generic at Kaiser facility/$20 copay generic at network pharmacies (for 1st fill only). $25 brand at Kaiser facility/$35 brand at network pharmacies (for 1st fill only). 2x copay for 90-day supply via mail order at Kaiser facility.

How to locate a BlueChoice HMO provider

1. Go to **bcbsga.com/bor**
2. Click on **Find a Doctor**
3. Click on **Georgia Providers for Individual Plans and Group Plans** (through your employer)
4. Complete Steps 2 and 3
5. In Step 4, Plan Type, choose **HMO** from the drop down
6. In Step 5, Plan Name, choose **BlueChoice Healthcare Plan** from the drop down

For Kaiser HMO and Kaiser Senior Advantage 65+ go to kp.org

What is the advantage of enrolling in the HSA Open Access POS plan?

The HSA Open Access POS plan allows you to take control of your health care dollars. Instead of paying a high premium which covers most of your health costs over the plan year, the HSA Open Access plan has lower premiums and you use your own pre-tax savings in your health savings account (HSA) to pay for out-of-pocket medical and prescription drug expenses until your reach your deductible. After you meet your deductible, you pay 10% of the in-network costs for medical care and prescriptions. Out-of-network services will cost you more out-of-pocket.

The benefits of enrolling in the HSA Open Access POS plan include:

- Allows you to save money through lower monthly premiums
- Gives you the ability to save pre-tax money for current and future eligible out-of-pocket medical and prescription drug expenses in a health savings account which rolls over from year to year
- Gives you more control over your health care dollars and encourages you to be healthy
- Gives you the flexibility to see specialists without a referral

How does the HSA Open Access POS plan work?

- Stay healthy with your Preventive Care Benefits. Covered at 100% (does not accumulate towards deductible)
- You set up a Health Savings Account. You receive employer matching contributions on your contributions (dollar for dollar) each pay date up to the maximum annual employer contribution limit which is $375 for employee only coverage and $750 for family coverage
- You use your HSA to pay for out-of-pocket medical care and prescription drugs before and after the deductible
- Traditional Health Coverage kicks in after you have satisfied your deductible

What is a Health Savings Account?

An Health Savings Account (HSA) is a pre-tax savings account that employees enrolled in the HSA Open Access POS plan are allowed to open and contribute to for use towards qualified out-of-pocket medical expenses. You designate an amount to contribute annually and this amount is divided over the number of payrolls in the year. Each pay date, your contributions are withheld from your paycheck pre-tax and deposited in your HSA. Then you are able to use the money in your account towards out-of-pocket medical expenses and pharmacy costs up to the deductible and after the deductible is met. In 2013, your institution will match your pre-tax, payroll contributions dollar for dollar up to the employer match limit of $375 for employee only coverage or $750 for family coverage.

You will receive an HSA Debit card for you to use at doctor's offices and at the pharmacy. Keep in mind, the card you receive is a Debit card in the true sense that you can never charge more than what is in your account.

Until you meet your deductible, you will pay out-of-pocket for the full (negotiated) rate for health services and prescriptions in the HSA Open Access POS plan. Most providers will not charge you at the office and will submit the claim to BCBSGa for payment. If you have not met your deductible, once BCBSGa approves the claim, the provider's office will bill you the negotiated rate for services and you use your savings in your HSA to pay the provider.

Even though you do not need receipts to be reimbursed, always keep a receipt for every withdrawal (or distribution). If you are ever audited by the IRS, you will need to provide proof that each withdrawal was for an eligible medical expense or it will be subject to taxes and a penalty.

To be eligible to open an HSA, you must meet the following criteria:

- Covered under a High Deductible Health Plan; the HSA Open Access POS plan is a High Deductible Health Plan
- Not be covered under any other health plan that is not an High Deductible Health Plan
- Not currently enrolled in Medicare or TRICARE
- Not claimed as dependent on another person's tax return
- Not received medical benefits through the VA during the preceding 3 months

Money in this account rolls over from year to year. If you leave employment or move to another plan option, this account is always yours and the funds are available to use towards eligible out-of-pocket medical expenses. However, unless you are enrolled in a High Deductible Health plan, you will be unable to make contributions to this account. Once you turn age 65, the funds may be used as supplemental income and withdrawals will be taxed but not subject to a penalty.

The IRS sets the maximum you may contribute pre-tax each year. In 2013, the maximums are as follows:

Single: $3,250 (or $2,875 net of the employer match)

Family: $6,450 (or $5,700 net of employer match)

Catch-up: $1,000 for employees 55 or older

For more information about Health Savings Accounts, please visit the University System of Georgia website at: usg.edu/hr/benefits or the IRS website at: irs.gov/pub/irs-pdf/p969.pdf

Preventive Care 100% In-Network → **HSA-Health Savings Account:** funded by your pre-tax payroll contributions and the Employer Contribution → **Annual Deductible:** $1,500 for single and $3,000 for family must be met before plan pays any benefits; applies to health care and prescription drug costs → **Traditional Health Coverage:** Plan pays 90% benefit in-network up to annual out-of-pocket maximum $3,000 individual and $6,000 family for in-network care

Information about Blue Cross and Blue Shield and Kaiser Permanente programs and services to help you manage your health

Blue Cross and Blue Shield of Georgia 360° Health Programs

ConditionCare Programs 800-785-0006

- Diabetes (pediatric and adult)
- Asthma (pediatric and adult)
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- 24/7 NurseLine 800-785-0006
- MyHealth Coach 800-785-0006
  - Hypertension
  - Hyperlipidemia
  - Low-Back Pain
  - Oncology (addressing prostate, skin, breast, colon & lung cancer)

Online Member Access at (bcbsga.com/bor) - A secure online transaction service that allows you to:

- Request a new member ID card.
- Check claims status.
- View your benefits details, benefits/deductibles used.
- Search the online provider directory to find network physicians, hospitals, specialists, and many other health care professionals, refine the search by gender and/or office availability, and print a map and driving directions.
- 360°Health is the gateway to leading a healthier life and becoming a more informed health care consumer.
- MyHealth Assessment: Receive an overall wellness snapshot (it compares your score against peers); reduce health risks to improve overall health status.
- Nutrition Improvement Program: Helps you to understand more about yourself and your food choices.
- Childhood Immunization Scheduler: Provides relevant age-related tools and information for newborns through children six years old.
- Exercise Program: Created by an Olympic coach, this program lets you measure and manage your fitness, or be guided by fitness and health experts.
- Special Offers: Wide-ranging discount program that allows you and your family to take a personal path towards wellness. Complementary and alternative medicine, fitness and nutrition, vision services products, and more.
- Smoking Cessation program: Combines conventional smoking cessation and interactive Web experiences. Designed by a former smoker, the comprehensive 10-session/4-week program is based on solid behavioral change science. The program is offered free of charge. For more information, view the Lifestyle Improvement programs on the Health and Wellness tab at bcbsga.com/bor.

Kaiser Permanente Programs

Kaiser Permanente has been providing members with innovative disease management programs for more than 60 years. In recent years, our programs have evolved into a patient-centered model of total health called the Kaiser Permanente Complete Care Program.

Our Complete Care disease management (DM) program includes:

- Asthma (adult/pediatric)
- Diabetes
- Cardiovascular Disease
- Chronic Heart Failure (CHF)
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Hypertension (integrated with CAD/CHF)
- Sickle Cell Anemia
- HIV/AIDS (chronic condition)
- Low-Back problems (chronic condition)
- Osteoporosis (chronic condition)
- Obesity/Weight Management – Eating disorders (chronic condition)

Each of these programs has a variety of components, including evidence-based guidelines for screening and treatment; general and targeted outreach and reminders to members; patient education and self-management tools and resources for member engagement and compliance; specialty services (e.g., diabetic nurse educators, and Clinical Pharmacy Services to improve cholesterol control for members with CAD); and physician feedback regarding performance measures. Our fully integrated delivery system allows for a high degree of physician participation in these programs.

On-line member services available through kp.org

Our members'-only website (www.kp.org) adds to members' care experience in several important ways.

Members can:

- Use the Knowledge Base (health encyclopedia) to find answers to their questions about a certain disease or drug.
- Use our specialized chat rooms providing interaction and support in a large number of areas of health interest and concerns.
- Refill prescriptions either for mail order or pick up from a Kaiser Permanente pharmacy.
- Access featured health topics, including a member version of our clinical practice guidelines.
- Access a confidential health risk assessment tool (measuring body mass index, calcium intake, pregnancy due dates, asthma triggers, and risk for depression, alcohol abuse, cancer and more); as well as behavior change modules such as our award-winning Balance® - healthy weight and fitness; Breathe® - smoking cessation; Nourish® - proper nutrition; and Relax® - stress reduction.
- Access the HealthyRoads program containing health information related to complementary and alternative medical choices, information on discounts to chiropractic services, acupuncture, massage therapy, and health clubs.
- Schedule an appointment to see a physician, send and receive email messages from their health coach or provider, ask questions of an advice nurse or pharmacist, review lab results, medical conditions, prescription information, and office visit summaries.
- Obtain information regarding treatment options and prevention tips about major medical conditions, review a listing of Shared Decision Making video topics, and speak with a health coach regarding which topic is right for them.

Pharmacy Benefit Manager

Open Access POS Plan: Express Scripts

The Board of Regents has chosen Express Scripts to manage the Open Access POS plan Pharmacy Benefit and to manage a Coverage Review Program. Effective January 1, 2013, your plan will include a Home Delivery Benefit.
Your pharmacy benefit options are:

Retail pharmacies

Use a participating retail pharmacy for short-term prescriptions (such as antibiotics to treat infections). Be sure to show your Plan ID card to the pharmacist. To find a participating retail pharmacy near you, visit www.bcbsga.com and click "Find a Doctor."

Home Delivery with Express Scripts

When you use the Home Delivery service with Express Scripts, you can get up to a 90-day supply of long-term medications (those taken for 3 months or more). When you order online, you can save money by getting up to a 90-day supply of each covered medication for just one mail-order payment, and standard shipping is free. The applicable copayment for a 90-day supply will be charged even if your prescription is for a 31-day supply. Medications are dispensed by registered pharmacists and are usually delivered directly to your home or office within 5 days after the ordered is received. You can order refills online, by mail, or by phone – 24 hours a day, 7 days a week.

Retail Pharmacy Up to a 30-day supply	Generic Copayment: $10, Preferred Brand-Name Copayment: $30 Nonpreferred Brand Name: 20% copayment of nonpreferred brand-name drug cost, with minimum member copayment of $45/maximum member copayment of $100, for up to a 30-day supply.
Home Delivery Up to a 90-day supply	Generic Copayment: $25, Preferred Brand-Name Copayment: $75 Nonpreferred Brand Name: 20% copayment of nonpreferred brand-name drug cost, with minimum member copayment of $112.50/maximum member copayment of $250, for up to a 90-day supply. **The applicable copayment for a 90-day supply will be charged even if your prescription is for a 31-day supply.
Additional Copayment Information	• If the usual and customary charge for a generic or preferred brand-name drug is less than the copayment amount, the member will pay the lesser of the two. • If a physician indicates "Brand Necessary" on a prescription, then only a preferred or nonpreferred brand-name medication can be dispensed. The member will be responsible for the preferred/nonpreferred brand-name medication copayment. • If a physician does not indicate "Brand Necessary" and the member chooses a preferred/nonpreferred brand-name medication over its available generic equivalent, the member will be required to pay the generic copayment. In addition to paying the generic copayment, the member will also be responsible for paying the difference in the cost between the generic and the preferred/nonpreferred brand-name drug. This difference in member cost is sometimes referred to as an "ancillary charge."
Annual Out-of-Pocket Maximum Doesn't apply to nonpreferred	The following annual out-of-pocket maximum amounts for members who obtain generic and preferred brand-name prescription medications will apply: • Employee: $1,000 • Employee + Child: (Two (2) covered members): $2,000 • Employee + Spouse: (Two (2) covered members): $2,000 • Family: (Three (3) or more covered members): $3,000 Upon a member reaching his or her annual out-of-pocket maximum, his or her prescription drug copayments will be waived for any additional generic and preferred brand-name medications for the remainder of that year.
Maintenance Medications	Maintenance medications are those prescription drugs that a member may obtain for a period of up to 90 days. The member will be charged one retail copayment for each supply of medication up to a 30-day supply. For Mail Order prescriptions, the member will pay the applicable mail order copayment for up to a 90-day supply.
Coverage Reviews/ Prior Authorization	Some medications are not covered unless you receive approval through a coverage review (prior authorization). This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe and effective. There are other medications that may be covered, but with limits (for example, only for a certain amount or for certain uses) unless you receive approval through a review. During this review, Express Scripts asks your doctor for more information than what is on the prescription before the medication may be covered under your plan. Network pharmacists and physicians have been advised that the University System of Georgia will participate in this program. If you should go to a pharmacy and you are informed that your prescription cannot be filled because it requires a prior authorization, please have your physician contact Express Scripts to complete the coverage review.
Important Notes	• Copayments for nonpreferred brand-name medications will NOT apply to the annual out-of-pocket maximum benefit. • Prescription drug copayments do NOT apply to University System of Georgia medical annual deductibles or to medical maximum annual out-of-pocket limits. • If the member purchases a preferred brand-name prescription drug that is not indicated as "Brand Necessary," and there is a generic equivalent available; only the generic member copayment will be applied to the annual maximum out-of-pocket member benefit. The difference in cost between the generic equivalent and the preferred brand-name medication will NOT apply to the annual maximum out-of-pocket member benefit. • Prescription drug copayments covered by the health care plan will not be changed or overridden on an individual basis. • There is no Coordination of Benefits (COB) for allowed pharmacy charges between the Board of Regents pharmacy plan and another pharmacy/medical plan in which the member may be enrolled. • Specialty drug vendor is Accredo. • For Medicare Part B covered prescriptions please contact Member Services.

Other Coverage Rules

For specific prescribed drugs, the plan may impose certain requirements. Those requirements may include prior authorization, limits on the day supply amount of the prescribed medication, and/or limits on the number of approved units/tablets of medication per prescription.

Coverage Management Program

This program is a prescription drug protocol management resource that promotes the utilization of first-line medications and/or therapeutic categories. Under this program, your plan will usually cover a proven, less expensive medication that is known to be safe and effective as an initial treatment strategy. If the initial covered medication(s) does not work for you, you or your physician may request a review to obtain coverage for an alternative treatment strategy. A coverage review or "prior authorization" may be required before a member is approved for coverage of a new prescription drug medication. This review is necessary to determine how your prescription drug plan may cover certain medications.

Plan coverage for retirees

Blue Cross and Blue Shield of Georgia

A retired member age 65 or older has the option to select the Open Access POS plan or the HSA Open Access POS plan. Please note if you are retired and Medicare eligible, you can elect the HSA Open Access POS, but you cannot open or contribute to a Health Savings Account (HSA). The BlueChoice HMO does not offer a Medicare-eligible retiree health care plan, therefore it is not available for retirees who are Medicare-eligible.

Open Access POS plan pharmacy coverage

As a retiree over age 65 in the Open Access POS plan, your pharmacy coverage will be provided through an Express Scripts Medicare approved Part D plan. Pharmacy benefits remain approximately the same as those listed on page 22. Retirees enrolled in this plan will not be able to enroll in other Medicare Part D coverage.

Kaiser Permanente SENIOR ADVANTAGE HMO Plan: A Medicare Advantage Plan with Part D

Kaiser Permanente is the only HMO health care plan option that provides Board of Regents members with access to a Medicare Advantage plan. The Kaiser Permanente Medicare option is called "Senior Advantage." For our retirees who wish to receive their entire medical and enhanced drug benefits from one source, the Kaiser Permanente Senior Advantage option provides an integrated benefit covering hospital, physician and drug costs.

For a Medicare retiree to qualify for the Kaiser Permanente Senior Advantage HMO Plan, he or she and all of his or her covered dependents must have Medicare Parts A and B and must assign coverage to the HMO vendor. The Kaiser Permanente Senior Advantage HMO product will serve as the member's only health care plan. There will be no secondary benefits from Medicare.

If an individual fails to qualify for participation in the Kaiser Permanente Senior Advantage Plan, the respective HMO plans offered for active employees will NOT be available to Medicare-eligible retirees.

Service Area

Participating retirees must reside within the Medicare Advantage service area to be eligible for benefit coverage.

The Kaiser Permanente Senior Advantage HMO Plan is available to members who reside in the following metropolitan Atlanta counties: Barrow, Bartow, Butts, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale, Spalding and Walton.

The Kaiser Permanente Senior Advantage Plan is a separate HMO product. The service area and the Physician Network are slightly different than those for the Kaiser Permanente HMO Plan.

The Kaiser Permanente Senior Advantage HMO product will NOT be available for Medicare-eligible retirees who do not reside in the Senior Advantage service area.

If you are interested in the Kaiser Permanente Senior Advantage Plan, please contact Kaiser Permanente for an enrollment packet. A member who enrolls in the Kaiser Permanente Senior Advantage Plan will be required to complete a separate Senior Advantage enrollment form and will be required to reside within the Senior Advantage service area.

Kaiser Senior Advantage Pharmacy coverage

If you enroll in the Kaiser Permanente Senior advantage plan, Kaiser Permanente will serve automatically as your Part D provider. If you are a new member selecting Kaiser Permanente Senior Advantage as your retiree option for 2013, your application will include Part D enrollment information. If you currently have an existing Part D Plan and enroll into Senior Advantage, your existing Part D Plan will automatically be cancelled by Medicare. Customer Service is available to answer your questions at 404-233-3700, or 800-232-4404.

Take care of yourself

Remember to get preventive care!

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans and policies cover 100% of the services listed in this preventive care section when you get these services from doctors in your plan's network.[1]

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses.

For example, say your doctor suggests you have a colonoscopy because of your age. That's preventive care. On the other hand, say your doctor suggests a colonoscopy to see what's causing your symptoms. That's diagnostic care and you may need to pay part of the cost.

Here's an overview of the types of preventive services we cover. See your benefits summary to learn more.

Child preventive care (birth through 18 years)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests (depending on your age) may include

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cholesterol and lipid level
- Depression
- Development and behavior
- Hearing
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- Lead testing
- Newborn
- Obesity, including counseling
- Oral (dental health)
- Sexually transmitted infections
- Vision[2]

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chicken pox)

Adult preventive care (19 years and older)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests and services (depending on your age) may include

- Aortic aneurysm screening (men who have smoked)
- Blood pressure
- Bone density test to screen for osteoporosis
- Breast cancer, including exam and mammogram
- **Breastfeeding support, supplies and counseling (female)**[3, 4]
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- **Contraceptive (birth control) counseling and FDA-approved birth control methods that need a prescription (female)**[4, 5]
- Depression
- Eye chart test for vision[2]
- Hearing
- Height, weight and BMI
- HIV screening
- **HPV (female)**[4]
- Intervention services (includes counseling and education):
  - Behavioral counseling to promote a healthy diet
  - Counseling related to aspirin use for the prevention of cardiovascular disease (does not include coverage for aspirin)
  - Genetic counseling for women with a family history of breast or ovarian cancer
  - Primary care intervention to promote breastfeeding
  - Screening and behavioral counseling related to alcohol misuse
  - Screening and behavioral counseling related to tobacco use
  - Screening and counseling for interpersonal and domestic violence
  - Screening and counseling for obesity
- Pelvic exam and Pap test, including screening for cervical cancer
- Prostate cancer, including digital rectal exam and PSA test
- Screenings during pregnancy (including, but not limited to, **gestational diabetes**[4], hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)
- Sexually transmitted infections

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A
- Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- MMR
- Pneumococcal (pneumonia)
- Varicella (chicken pox)
- Zoster (shingles)

This sheet is not a contract or policy with BCBSGa. If there is any difference between this sheet and the policy, the provisions of the policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions & Limitations.

1 Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

2 Some plans and policies cover additional vision services. Please see your contract or Certificate of Coverage for details.

3 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

4 This benefit is covered under health care reform's women's preventive services. For group plan members, these services are covered with policy years beginning after August 1, 2012. For members with individual coverage, these benefits are effective for new members on or after August 1, 2012 and for current members on January 1, 2013. This benefit also applies to those younger than 19.

5 To get 100% coverage for a covered prescription for birth control, it must be a generic drug or a brand-name drug that doesn't have a generic equivalent. Also, you'll need to fill the prescription at an in-network pharmacy. A cost-share may apply for other prescription contraceptives, based on your drug benefits.

For more information

Blue Cross and Blue Shield of Georgia, Inc.

All BCBSGa Products:

BOR Dedicated Customer Service Unit	**800-424-8950/TDD 404-842-8073**
Behavioral Health Services	**800-292-2879/TDD 404-842-8073**
Online Tools and Provider Search	**bcbsga.com/bor**
24/7 NurseLine	**800-785-0006/TDD 800-368-4424**
Precertification	**800-233-5765/TDD 800-368-4424**
MyHealth Coach	**800-785-0006/TDD 800-368-4424**
ConditionCare	**800-785-0006/TDD 800-368-4424**
Pharmacy Benefits	**800-424-8950/TDD 404-842-8073**

Pharmacy Benefits Manager for Open Access POS

Express Scripts	**877-300-5139/TDD 800-759-1089**

Call for information regarding your pharmacy benefit plan and covered benefits 24 hours a day, seven days a week. The number is also available during the open enrollment period. The 2012 Preferred Drug List will be available online at usg.edu/hr/benefits/health_insurance.

Board of Regents of the University System of Georgia

270 Washington Street, SW, Atlanta, GA 30334

The University System of Georgia will link vendor information to its website:

usg.edu/hr/benefits/health_insurance

Kaiser Permanente HMO

Kaiser Permanente	**404-261-2590/TDD 800-255-0056** outside of Atlanta **888-865-5813**
Kaiser Permanente Senior Advantage	**404-233-3700/TDD 800-255-0056** outside of Atlanta **800-232-4404**

For information regarding benefits and participating network providers:

Behavioral Health Services	**404-261-2590/TDD 800-255-0056** (Mental Health and Substance Abuse) outside of Atlanta **888-865-5813**

Members may self-refer for these services. Kaiser Permanente must preauthorize all mental health/substance abuse treatment and care.

Kaiser Permanente's Advice Line	metro Atlanta **404-365-0966** outside of Atlanta **800-611-1811**

For emergency room referral and for medical information from a registered nurse, 24 hours a day, seven days a week.

Online Provider Information: kp.org

Disclaimer

This material is for informational purposes and is not a contract. It is intended only to highlight principal benefits of the medical plans. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan documents, the Plan documents govern. It is the responsibility of each member, active or retired, to read all Plan-provided materials to fully understand the provisions of the option chosen.

Glossary

Balance Billing

The dollar amount charged by a provider that is in excess of the plan's allowed amount for medical care or treatment. Amounts that are balance billed by a provider are the member's responsibility. Member costs incurred for balance billing will not apply toward the annual deductible or toward the annual maximum out-of-pocket limits.

Coinsurance

Coinsurance is the portion of the covered allowed charges that a member must pay, after he/she has met the appropriate deductible. If the healthcare plan covers 90% of the cost for a particular benefit, the member would be responsible for the remaining 10% of covered charges. The 10% of covered allowed charges, paid by the member, is deemed to be the coinsurance amount and accumulates towards annual out-of-pocket limit.

Co-payment

A co-payment is a fixed dollar amount that a member must pay for a particular service or item, such as a member co-payment for a prescription medication.

Deductible

A deductible is a fixed dollar amount that a member must pay out-of-pocket, each plan year, before the healthcare plan will begin to pay for covered benefits.

Emergency Care

Emergency care is medical care that is provided for a sudden, severe, and/or unexpected illness/injury. If such care/treatment were not provided immediately, the results could be life threatening or could result in permanent impairment of bodily functions.

Out-of-Pocket Limit

An out-of-pocket limit is the maximum amount of healthcare plan expenses that a member will be required to pay during a plan year. Pharmacy is not included in the out-of-pocket limit on the Open Access POS plan. Out-of-pocket expenses include member deductibles and member co-insurance payments required on an annual plan year basis.

"Creating A More Educated Georgia"

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