




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-397-9267. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-397-9267 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$1,500/member or \$3,000/family for In- <u>Network Providers</u> . \$3,000/member or \$6,000/family for Non- <u>Network Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</u> for In- <u>Network Providers</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$3,000/member or \$6,000/family for In- <u>Network Providers</u> . \$6,000/member or \$12,000/family for Non- <u>Network Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes, Blue Open Access POS. See <a href="http://www.anthem.com">www.anthem.com</a> or call (855) 397-9267 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>Out-of-Network Provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist visit</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	Non- <u>network</u> <u>preventive</u> care services for children prior to their 6th birthday have no <u>deductible</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Costs may vary by site of service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <u><a href="http://www.anthem.com/pharmacyinformation/">prescription drug coverage</a></u> is available at <u><a href="http://www.anthem.com/pharmacyinformation/">www.anthem.com/pharmacyinformation/</a></u>	Tier 1 – Typically Generic Drugs	10% <u>coinsurance</u> (retail and home delivery)	40% <u>coinsurance</u> (retail only)	Some drugs require prior authorization or no benefits provided. Some drugs subject to step therapy, quantity limitations and other utilization management requirements. Only drugs listed on the <u>formulary</u> are covered. Not all <u>prescription drugs</u> are covered. Retail drugs limited to up to 30-day supply; home delivery and maintenance pharmacy limited to up to 90-day supply. First 30-day supply and one refill of maintenance medications may be filled at retail pharmacy. Thereafter, must be filled through home delivery or maintenance pharmacy. No charge for ACA-required generic preventive drugs, such as contraceptives (or brand name contraceptives if a generic is not medically appropriate).
	Tier 2 – Typically Preferred Brand and Non-Preferred Generic Drugs	10% <u>coinsurance</u> (retail and home delivery)	40% <u>coinsurance</u> (retail only)	
	Tier 3 – Typically Non-Preferred Brand and Generic Drugs	10% <u>coinsurance</u> (retail and home delivery)	40% <u>coinsurance</u> (retail only)	
	Typically Preferred <u>Specialty Drugs</u> (Brand and Generic)	10% <u>coinsurance</u> (retail and home delivery)	40% <u>coinsurance</u> (retail only)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	10% <u>coinsurance</u>	Covered as in- <u>network</u>	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	Covered as in- <u>network</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u> , <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	120 days/benefit period for inpatient rehabilitation and <u>skilled nursing care</u> combined.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: 10% <u>coinsurance</u> ; Other outpatient: 10% <u>coinsurance</u>	Office visit: 40% <u>coinsurance</u> ; Other outpatient: 40% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you are pregnant	Office visits	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	120 visits/benefit period.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Costs may vary by site of service. The following visit limits apply in-network and out-of-network combined, and for office and outpatient visits combined. Physical and occupational therapy limited to 20 visits per benefit period; speech therapy limited to 20 visits per benefit period; chiropractic care limited to 20 visits per benefit period.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limits do not apply if care is part of hospice care or inpatient facility services benefit. When therapies are rendered in the home, the home care visit limit applies instead of the therapy limits. Therapy visit limits do not apply to autism services.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	120 days/benefit period for inpatient rehabilitation and <u>skilled nursing care</u> combined.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Plan may limit coverage to rental, or purchase if less.
	<u>Hospice services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

#### Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Children's dental check-up</li> <li>Children's eye exam</li> <li>Children's glasses</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care (unless medically necessary)</li> <li>Weight loss programs (except as required under the Affordable Care Act)</li> </ul>	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic care (limited to 20 visits per year)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S. (See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a>)</li> </ul>	

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx); Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://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](http://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: Grievances and Appeals, P.O. Box 105449, Atlanta, GA 30548-5449; Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov); Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx).

#### Does this plan provide Minimum Essential Coverage? Yes

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

### Does this plan meet the Minimum Value Standards? Yes

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

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-397-9267.

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,070

What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,630

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$390

What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,890

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$130

What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,630

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