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/ or call 1-855-397-9267 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,800**/member or **$3,600**/family for In-Network Providers. **$3,600**/member or **$7,200**/family for Non-Network Providers.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care for In-Network Providers.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,600**/member or **$7,200**/family for In-Network Providers. **$7,200**/member or **$14,400**/family for Non- Network Providers.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	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.
Will you pay less if you use a network provider?	Yes, Blue Open Access POS. See www.anthem.com or call (855) 397-9267 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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
		Network Provider (You will pay the least)	Out-of-Network 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	10% coinsurance	40% coinsurance	None
	Specialist visit	10% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	Non-network preventive care services for children prior to their 6th birthday have no deductible. 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)	10% coinsurance	40% coinsurance	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacyinformation/	Tier 1 – Typically Generic Drugs	10% coinsurance (retail and home delivery)	40% coinsurance (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 formulary are covered. Not all prescription drugs 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% coinsurance (retail and home delivery)	40% coinsurance (retail only)	
	Tier 3 – Typically Non-Preferred Brand and Generic Drugs	10% coinsurance (retail and home delivery)	40% coinsurance (retail only)	
	Typically Preferred Specialty Drugs (Brand and Generic)	10% coinsurance (retail and home delivery)	40% coinsurance (retail only)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	Covered as in-network	None
	Emergency medical transportation	10% coinsurance	Covered as in-network	None
	Urgent care	10% coinsurance, deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	120 days/benefit period for inpatient rehabilitation and skilled nursing care combined.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	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% coinsurance; Other outpatient: 10% coinsurance	Office visit: 40% coinsurance; Other outpatient: 40% coinsurance	None
	Inpatient services	10% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	10% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	120 visits/benefit period.
	Rehabilitation services	10% coinsurance	40% coinsurance	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. 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.
	Habilitation services	10% coinsurance	40% coinsurance	
	Skilled nursing care	10% coinsurance	40% coinsurance	120 days/benefit period for inpatient rehabilitation and skilled nursing care combined.
	Durable medical equipment	10% coinsurance	40% coinsurance	Plan may limit coverage to rental, or purchase if less.
	Hospice services	10% coinsurance	40% coinsurance	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's eye exam
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless medically necessary)
- Weight loss programs (except as required under the Affordable Care Act)

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

- Bariatric surgery
- Chiropractic care (limited to 20 visits per year)
- Hearing aids
- Non-emergency care when traveling outside the U.S. (See www.bcbsglobalcore.com)

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, WestTower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, 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. 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: 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; 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.

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 plan's overall deductible	**$1,800**
Specialist coinsurance	**10%**
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	$1,800
Copayments	$0
Coinsurance	$1,080
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$2,980**

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

The plan's overall deductible	**$1,800**
Specialist coinsurance	**10%**
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	$1,800
Copayments	$0
Coinsurance	$380
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,180**

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

The plan's overall deductible	**$1,800**
Specialist coinsurance	**10%**
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	$1,800
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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