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 770-997-9910 or toll-free at 800-241-2136. 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:/healthcare.gov/sbc-glossary or call 770-997-9910 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,250 / individual	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive services, network provider office visits, prescription drugs, preventive dental services and vision 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. $150 per visit for emergency room care; Dental services - $25/individual. 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?	$6,500/individual	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Non-network provider charges, premiums, balance billing, penalties for failure to obtain preauthorization, dental or vision services (except those covered under major medical), 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. See www.bcbsga.com or call 1-855-397-9267 for a list of Blue Open Access POS network providers when seeking care in Georgia or BlueCard PPO network providers if seeking care in another state.	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)	Non-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	$30 copay/visit. Deductible does not apply.	Not covered	$5 copay/visit for visits completed through LiveHealth Online (www.livehealthonline.com)
	Specialist visit	$40 copay/visit. Deductible does not apply.	Not covered	None
	Preventive care/screening/ immunization	No Charge. Deductible does not apply.	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% coinsurance	Not covered	Preauthorization is requested. Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Retail: $6 copay/script Home Delivery: $10 copay/script.	Not covered	Deductible does not apply. Coverage is limited to 30-day supply for non-maintenance and specialty drugs. Coverage is limited to 90-day supply for maintenance drugs. Coverage for Home Delivery is limited to maintenance medications only. If brand name drug is requested when there is an equivalent generic alternative, you will be required to pay the difference in cost between the brand name and generic. Coverage for certain medications may be subject to step therapy, preauthorization or other utilization management programs. Failure to obtain preauthorization will result in the drug not being covered. Specialty drugs must be obtained through the
	Preferred brand drugs	Retail: Greater of $35 copay/script or 25% coinsurance Home Delivery: Lesser of $105 copay/script or 20% coinsurance	Not covered	
	Non-preferred brand drugs	Retail: Greater of $45 copay/script or 35% coinsurance Home Delivery: Lesser of $155 copay/script or 30% coinsurance	Not covered	
	Biosimilar Specialty drugs	Lesser of $100 copay/ script or 8% coinsurance	Not covered	
	Preferred Specialty drugs	Lesser of $250 copay/ script or 15% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Non-Preferred Specialty drugs	Lesser of $400 copay/ script or 25% coinsurance	Not covered	BriovaRx Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance (20% coinsurance if use BDC or BDC+ facility for certain services)	Not covered	Preauthorization is required. If you don't get preauthorization, all charges may be denied. To only pay 20% coinsurance on facility fees for bariatric, cardiac, knee replacement, hip replacement, spine or transplant surgeries, you must use a hospital designated as a Blue Distinction Center or Blue Distinction Center + (BDC or BDC+). Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Physician/surgeon fees	30% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$150/visit then 30% coinsurance	Covered as In-Network	If admitted to the hospital, the $150 deductible is waived.
	Emergency medical transportation	30% coinsurance	Covered as In-Network	None
	Urgent care	$50 copay/visit. Deductible does not apply.	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance (20% coinsurance if use BDC or BDC+ facility for certain services)	Not covered	Preauthorization is required. If you don't get preauthorization, benefits payable may be reduced by 50%. To only pay 20% coinsurance on facility fees for bariatric, cardiac, knee replacement, hip replacement, spine or transplant surgeries, you must use a hospital designated as a Blue Distinction Center or Blue Distinction Center + (BDC or BDC+). Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Physician/surgeon fees	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit. Deductible does not apply. 30% coinsurance/ other outpatient services	Not covered	Preauthorization is requested for outpatient services other than office visits.
	Inpatient services	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits payable may be reduced by 50%.
If you are pregnant	Office visits	$40 copay/office visit. Deductible does not apply.	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance and deductible may apply to office visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No coverage for dependent child pregnancy, except for certain preventive services. Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Preauthorization is requested.
	Rehabilitation services	30% coinsurance	Not covered	None
	Habilitation services	30% coinsurance	Not covered	None
	Skilled nursing care	30% coinsurance	Not covered	Preauthorization is requested.
	Durable medical equipment	30% coinsurance	Not covered	Preauthorization is requested.
	Hospice services	30% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for dependent children
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	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.)

- Cosmetic Surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law
- Dental care (child)
- Hearing aids
- Long Term Care
- Routine eye care (child)
- Weight loss programs

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

- Acupuncture
- Bariatric surgery, if pre-certified and determined to be medically necessary
- Chiropractic care, limited to covered charges of $25/visit and 25 visits/year
- Dental care (adult), limited to $1,000
- Infertility treatment, except in vitro fertilization
- Non-emergency care when traveling outside the U.S. (visit www.anthem.com)
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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: the plan at 770-997-9910 or toll-free at 1-800-241-2136 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For insured dental and vision benefits, you can contact your State Department of Insurance. In Georgia, contact the Georgia Office of Insurance and Safety Fire Commissioner at 1-800-656-2298 or www.oci.ga.gov/consumerservice/home.aspx. In Alabama, contact the Alabama Department of Insurance at 334-241-4141 or www.aldoi.gov/ContactUs.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 1-866-533-5011 PIN 4360.

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	$1,250
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$1,250
Copayments	$10
Coinsurance	$3,390
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,710**

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

The plan's overall deductible	$1,250
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$0
Copayments	$890
Coinsurance	$780
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,670**

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

The plan's overall deductible	$1,250
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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*	$1,400
Copayments	$90
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,1770**

* This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 800-515-1468 or https://ufcwempatl.hmchealthworksco.com.

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