




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:
<b>What is the overall <a href="#">deductible</a>?</b>	\$875 / individual or \$1,750 / family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive services</a> , <a href="#">network provider</a> office visits, <a href="#">prescription drugs</a> , preventive dental services and vision services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$150 per visit for <a href="#">emergency room care</a> ; Dental services - \$25/individual or \$50/family. There are no other specific <a href="#">deductibles</a>	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$6,000 / individual, \$12,000 / family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> , penalties for failure to obtain <a href="#">preauthorization</a> , dental or vision services (except those covered under major medical), and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-833-664-2851 for a list of Blue Open Access POS <a href="#">network providers</a> when seeking care in Georgia or BlueCard PPO <a href="#">network providers</a> if seeking care in another state.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

Important Questions	Answers	Why This Matters:
see a <a href="#">specialist</a> ?		

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	\$5 <a href="#">copay</a> /visit for visits completed through LiveHealth Online ( <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> ) \$15 <a href="#">copay</a> /visit for visits completed at a retail health clinic
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge. <a href="#">Deductible</a> does not apply.	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is requested. Certain services received from <a href="#">non-of-network providers</a> while at an in- <a href="#">network</a> facility will be covered as in- <a href="#">network</a> .
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	Not covered	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	Retail: \$6 <a href="#">copay</a> /script Home Delivery: \$10 <a href="#">copay</a> /script.	Not covered	<a href="#">Deductible</a> 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
	Preferred brand drugs	Retail: Greater of \$35 <a href="#">copay</a> /script or 25% <a href="#">coinsurance</a> Home Delivery: Lesser of \$105 <a href="#">copay</a> /script or 20% <a href="#">coinsurance</a>	Not covered	
	Non-preferred brand drugs	Retail: Greater of \$45 <a href="#">copay</a> /script or 35% <a href="#">coinsurance</a> Home Delivery: Lesser	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)	
	Biosimilar <a href="#">Specialty drugs</a>	of \$155 <a href="#">copay</a> /script or 30% <a href="#">coinsurance</a> Lesser of \$100 <a href="#">copay</a> /script or 8% <a href="#">coinsurance</a>	Not covered	subject to step therapy, <a href="#">preauthorization</a> or other utilization management programs. Failure to obtain <a href="#">preauthorization</a> will result in the drug not being covered.  Specialty drugs must be obtained through the Optum Specialty Pharmacy.
	Preferred <a href="#">Specialty drugs</a>	Lesser of \$250 <a href="#">copay</a> /script or 15% <a href="#">coinsurance</a>	Not covered	
	Non-Preferred <a href="#">Specialty drugs</a>	Lesser of \$400 <a href="#">copay</a> /script or 25% <a href="#">coinsurance</a>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a> (20% <a href="#">coinsurance</a> if use BDC or BDC+ facility for certain services)	Not covered	<a href="#">Preauthorization</a> is required. If you don't get preauthorization, all charges may be denied. To pay only 20% <a href="#">coinsurance</a> 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 <a href="#">non-network providers</a> while at an in- <a href="#">network</a> facility will be covered as in- <a href="#">network</a> .
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150/visit then 30% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	If admitted to the hospital, the \$150 <a href="#">deductible</a> is waived.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	Emergency services provided at a <a href="#">non-network</a> Urgent Care center licensed to operate as a freestanding emergency department may be covered as in- <a href="#">network</a> .

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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a> (20% <a href="#">coinsurance</a> if use BDC or BDC+ facility for certain services)	Not covered	<p><a href="#">Preauthorization</a> is required. If you don't get preauthorization, benefits payable may be reduced by 50%.</p> <p>To only pay 20% <a href="#">coinsurance</a> 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+).</p> <p>Certain services received from <a href="#">non-network providers</a> while at an in-<a href="#">network</a> facility will be covered as in-<a href="#">network</a>.</p>
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply. 30% <a href="#">coinsurance</a> / other outpatient services	Not covered	<a href="#">Preauthorization</a> is requested for outpatient services other than office visits.
	Inpatient services	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. If you don't get preauthorization, benefits payable may be reduced by 50%.
<b>If you are pregnant</b>	Office visits	\$40 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	Not covered	<p><a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a>. Depending on the type of services, <a href="#">coinsurance</a> and <a href="#">deductible</a> 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 <a href="#">preventive services</a>. Certain services received from <a href="#">non-network providers</a> while at an in-<a href="#">network</a> facility will be covered as in-<a href="#">network</a>.</p>
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	Not covered	
<b>If you need help recovering or have other special health</b>	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is requested.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	Not covered	None

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)	
<b>needs</b>	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is requested.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is requested.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	Not covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge. <a href="#">Deductible</a> does not apply.	All charges in excess of \$30. <a href="#">Deductible</a> does not apply.	Limited to one exam/year. Not included in <a href="#">out-of-pocket limit</a> .
	Children's glasses	No Charge. <a href="#">Deductible</a> does not apply.	All charges in excess of \$35-\$75 (depending on lens type); \$62 (frames). <a href="#">Deductible</a> does not apply.	Limited to 1 set of glasses/year. Additional charges will apply for frames purchased from a <a href="#">network provider</a> over \$160 retail value or special coatings/tints to lenses. Not included in <a href="#">out-of-pocket limit</a> .
	Children's dental check-up	No Charge. <a href="#">Deductible</a> does not apply.	All charges over <a href="#">UCR</a> . <a href="#">Deductible</a> does not apply.	Limited to one exams/six months and \$1,000 annual maximum. Not included in <a href="#">out-of-pocket limit</a> .

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Cosmetic surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Pregnancy of a dependent child, except for mandated <a href="#">preventive services</a></li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery, if pre-certified and determined to be medically necessary</li> <li>Chiropractic care, limited to covered charges of \$25/visit and 25 visits/year</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (adult), limited to \$1,000 annual maximum</li> <li>Infertility treatment, except for services related to artificial insemination or assisted reproductive technology procedures</li> <li>Non-emergency care when traveling outside the U.S. (visit <a href="#">www.anthem.com</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](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 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](http://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](http://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](http://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](#) \$875
- [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$875
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$3,510
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,455</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$875
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$850
<a href="#">Coinsurance</a>	\$780
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,630</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$875
- [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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$1,030
<a href="#">Copayments</a>	\$90
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,520</b>

\* 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.