




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, visit [www.shbp.georgia.gov](http://www.shbp.georgia.gov) or call 1-855-641-4862. 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://www.healthcare.gov/sbc-glossary/> or call 1-855-641-4862 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>For <a href="#">network providers</a>: \$1,500 You   \$2,250 You + Spouse or Child(ren)   \$3,000 You + Family. For <a href="#">out-of-network providers</a>: \$3,000 You   \$4,500 You + Spouse or Child(ren)   \$6,000 You + Family</p>	<p>Generally, you must pay all of the costs from providers 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>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a>.</p>	<p>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>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>For <a href="#">network providers</a> \$4,000 You   \$6,000 You + Spouse or Child(ren)   \$8,000 You + Family. For <a href="#">out-of-network providers</a>: \$8,000 You   \$12,000 You + Spouse or Child(ren)   \$16,000 You + Family</p>	<p>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.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Copayments</a> for certain services, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://www.anthem.com/shbp">www.anthem.com/shbp</a></p>	<p>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">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</p>

Important Questions	Answers	Why This Matters:
	or call 1-855-641-4862 for a list of <a href="#">network providers</a> .	<a href="#">provider</a> for the difference between the provider's 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</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)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	There are childhood obesity visit limits.
	<a href="#">Specialist</a> visit	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	There are childhood obesity visit limits.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	Covered services must be properly coded as preventive and provided by a <a href="#">network provider</a> . No charge for hospital-based radiologist and anesthesiologist services provided by a non- <a href="#">network provider</a> at a <a href="#">network</a> facility and properly coded as preventive care for non- <a href="#">network providers</a> .
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	---None---
	Imaging (CT/PET scans, MRIs)	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	<a href="#">Preauthorization</a> may be required.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://info.caremark.com/shbp">http://info.caremark.com/shbp</a>	Generic drugs and select preferred brand drugs (Tier 1)	15% <a href="#">coinsurance</a> , with \$20 min/\$50 max (31-day supply)	Same <a href="#">coinsurance</a> and min/max as for <a href="#">network</a> , but based on the allowed amount.	For non-maintenance medication, there is a 31-day supply limit at retail pharmacies. Maintenance medications can be filled for up to a 90-day supply (retail or home delivery). For 32 – 62-day supply – monthly min/max is doubled.
	Preferred brand drugs (Tier 2)	25% <a href="#">coinsurance</a> with \$50 min/\$80 max (31-day supply)		
	Non-preferred brand drugs (Tier 3)	25% <a href="#">coinsurance</a> with \$80 min/\$125 max (31-day supply)	You must pay out-of-pocket and submit a paper claim for reimbursement.	

\* For more information about limitations and exceptions, see the plan or policy document at [www.shbp.georgia.gov](http://www.shbp.georgia.gov).

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)	
	<a href="#">Specialty drugs</a>	Same as Tier 1, Tier 2, and Tier 3 drugs as applicable.	The plan will reimburse you based on the allowed amount for <a href="#">network</a> pharmacies.	<p>63 or more day supply at a non 90-day retail <a href="#">network</a> pharmacy, monthly <a href="#">coinsurance</a> is tripled.</p> <p>63 or more day supply through home delivery, or 90-day retail network pharmacy, monthly min/max is multiplied by 2.5.</p> <p>Pharmacy coinsurance does not apply to the deductible; however it does apply to the out-of-pocket maximum. See the Plan Documents for a list of drugs that require <a href="#">preauthorization</a> or have other limits.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	<a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	Some providers are not covered as assistants at surgery. <a href="#">Preauthorization</a> may be required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	15% <a href="#">coinsurance</a> After Deductible	15% <a href="#">coinsurance</a> After Deductible	<a href="#">Preauthorization</a> is required within 1 business day, or as soon as possible, if you are admitted to a non- <a href="#">network</a> hospital.
	<a href="#">Emergency medical transportation</a>	15% <a href="#">coinsurance</a> After Deductible	15% <a href="#">coinsurance</a> After Deductible	---None---
	<a href="#">Urgent care</a>	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	Some providers are not covered as assistants at surgery. <a href="#">Preauthorization</a> may be required.

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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	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	Failure to obtain <a href="#">preauthorization</a> may result in non-coverage or reduced benefits.
	Inpatient services	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	Failure to obtain <a href="#">preauthorization</a> may result in non-coverage or reduced benefits.
If you are pregnant	Office visits	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	<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> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	<a href="#">Preauthorization</a> may be required.
	Childbirth/delivery facility services	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	Applies to inpatient facility. Other cost shares may apply depending on the services provided. <a href="#">Preauthorization</a> may be required.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	<a href="#">Preauthorization</a> may be required.
	<a href="#">Rehabilitation services</a>	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	There is a benefit maximum of 40 visits per therapy in a benefit year (physical, occupational, speech, cardiac rehab, pulmonary rehab). The limits do NOT apply to Mental Health Conditions. Physical, Occupational and Speech Therapy <a href="#">Preauthorization</a> is required for children only after 40 visits. The limits do NOT apply to Mental Health Conditions. Services provided by a Home Health agency are NOT subject to the 40-visit limitation when performed in a home setting. If performed in a home setting, the home health care benefit applies.
	<a href="#">Habilitation services</a>	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	Habilitation visits count toward the rehabilitation visit maximum above.
	<a href="#">Skilled nursing care</a>	15% <a href="#">coinsurance</a> After Deductible	Not Covered	Skilled Nursing Facility coverage is limited to 120 days per calendar year. <a href="#">Preauthorization</a> may be required.

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	<a href="#">Durable medical equipment</a>	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	<a href="#">Preauthorization</a> may be required.
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)	
	<a href="#">Hospice services</a>	15% <a href="#">coinsurance</a> After Deductible	40% <a href="#">coinsurance</a> After Deductible	<a href="#">Preauthorization</a> may be required. 8 bereavement visits per calendar year.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	1 routine exam every 24 months.
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic Surgery</li> <li>Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <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 Foot Care</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>Chiropractic care</li> <li>Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>Bariatric Surgery</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</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: Your state insurance department, Georgia Department of Insurance at 1-800-656-2298 or [www.oci.ga.gov/](http://www.oci.ga.gov/); or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [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. For more information on your rights to continue coverage contact, the plan at 1-800-610-1863.

**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](#). You should contact Anthem Blue Cross and Blue Shield directly to appeal denial of coverage for medical claims by calling 1-855-641-4862. For appeals related to well-being incentive credits, contact Sharecare, at 1-888-616-6411. For questions about your eligibility, rights, this notice, or assistance, you can contact: the State Health Benefit Plan Member Services at 1-800-610-1863 or access information about eligibility appeals at [www.shbp.georgia.gov](http://www.shbp.georgia.gov). 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 limitations and exceptions, see the plan or policy document at [www.shbp.georgia.gov](http://www.shbp.georgia.gov).

**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 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 1-855-641-4862.

\_\_\_\_\_ *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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1500
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	15%
■ Hospital (facility) [ <i>cost sharing</i> ]	15%
■ Other [ <i>cost sharing</i> ]	15%

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>\$7540</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1500
Copayments	\$0
Coinsurance	\$906
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2406</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1500
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	15%
■ Hospital (facility) [ <i>costsharing</i> ]	15%
■ Other [ <i>cost sharing</i> ]	15%

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>\$5400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1500
Copayments	\$0
Coinsurance	\$585
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2085</b>

\*Prescriptions are paid under the pharmacy benefit through CVS Caremark.

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1500
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	15%
■ Hospital (facility) [ <i>cost sharing</i> ]	15%
■ Other [ <i>cost sharing</i> ]	15%

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>\$1900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1500
Copayments	\$0
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1560</b>