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 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:
What is the overall deductible?	For network providers: **$2,500** You | **$3,750** You + Spouse or Child(ren) **$5,000** You + Family. For out-of-network providers: **$5,000** You | **$7,500** You + Spouse or Child(ren) | **$10,000** You + Family	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers **$6,000** You | **$9,000** You + Spouse or Child(ren) **$12,000** You + Family. For out-of-network providers: **$12,000** You | **$18,000** You + Spouse or Child(ren) | **$24,000** You + Family	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.anthem.com/shbp or call 1-855-641-4862 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	25% coinsurance After Deductible	40% coinsurance After Deductible	There are childhood obesity visit limits.
	Specialist visit	25% coinsurance After Deductible	40% coinsurance After Deductible	There are childhood obesity visit limits.
	Preventive care/screening/ immunization	No Charge	Not Covered	Covered services must be properly coded as preventive and provided by a network provider. No charge for hospital-based radiologist and anesthesiologist services provided by a non-network provider at a network facility and properly coded as preventive care for non-network providers.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance After Deductible	40% coinsurance After Deductible	---None---
	Imaging (CT/PET scans, MRIs)	25% coinsurance After Deductible	40% coinsurance After Deductible	Preauthorization 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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://info.caremark.com/shbp	Generic drugs and select preferred brand drugs (Tier 1)	15% coinsurance, with $20 min/$50 max (31-day supply)	Same coinsurance and min/max as for network, but based on the allowed amount. You must pay out-of-pocket and submit a paper claim for reimbursement. The plan will reimburse you based on the allowed amount for network pharmacies.	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. 63 or more day supply at a non 90-day retail network pharmacy, monthly coinsurance is tripled. 63 or more day supply through home delivery, or 90-day retail network pharmacy, monthly min/max is multiplied by 2.5. 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 preauthorization or have other limits.
	Preferred brand drugs (Tier 2)	25% coinsurance with $50 min/$80 max (31-day supply)		
	Non-preferred brand drugs (Tier 3)	25% coinsurance with $80 min/$125 max (31-day supply)		
	Specialty drugs	Same Tier 1, Tier 2, and Tier 3 drugs as applicable.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance After Deductible	40% coinsurance After Deductible	Preauthorization may be required.
	Physician/surgeon fees	25% coinsurance After Deductible	40% coinsurance After Deductible	Some providers are not covered as assistants at surgery. Preauthorization may be required.
If you need immediate medical attention	Emergency room care	25% coinsurance After Deductible	25% coinsurance After Deductible	Preauthorization is required within 1 business day, or as soon as possible, if you are admitted to a non- network hospital.
	Emergency medical transportation	25% coinsurance After Deductible	25% coinsurance After Deductible	---None---
	Urgent care	25% coinsurance After Deductible	40% coinsurance After Deductible	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance After Deductible	40% coinsurance After Deductible	Preauthorization is 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)	
	Physician/surgeon fees	25% coinsurance After Deductible	40% coinsurance After Deductible	Some providers are not covered as assistants at surgery. Preauthorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance After Deductible	40% coinsurance After Deductible	Failure to obtain preauthorization may result in non-coverage or reduced benefits.
	Inpatient services	25% coinsurance After Deductible	40% coinsurance After Deductible	Failure to obtain preauthorization may result in non-coverage or reduced benefits.
If you are pregnant	Office visits	25% coinsurance After Deductible	40% coinsurance After Deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance After Deductible	40% coinsurance After Deductible	Preauthorization may be required.
	Childbirth/delivery facility services	25% coinsurance After Deductible	40% coinsurance After Deductible	Applies to inpatient facility. Other cost shares may apply depending on the services provided. Preauthorization may be required.
If you need help recovering or have other special health needs	Home health care	25% coinsurance After Deductible	40% coinsurance After Deductible	Preauthorization may be required.
	Rehabilitation services	25% coinsurance After Deductible	40% coinsurance 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 Preauthorization 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.
	Habilitation services	25% coinsurance After Deductible	40% coinsurance After Deductible	Habilitation visits count toward the rehabilitation visit maximum above.

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)	
	Skilled nursing care	25% coinsurance After Deductible	Not Covered	Skilled Nursing Facility coverage is limited to 120 days per calendar year. Preauthorization may be required.
	Durable medical equipment	25% coinsurance After Deductible	40% coinsurance After Deductible	Preauthorization may be required.
	Hospice services	25% coinsurance After Deductible	40% coinsurance After Deductible	Preauthorization 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Weight loss programs
- Cosmetic Surgery
- Infertility Treatment
- Long Term Care
- Dental Care (adult)
- Private Duty Nursing
- Routine Foot Care

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

- Chiropractic care
- Hearing Aids
- Bariatric Surgery
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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/; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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. 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

* For more information about limitations and exceptions, see the plan or policy document at www.shbp.georgia.gov.

Services at 1-800-610-1863 or access information about eligibility appeals at 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.

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 plan's overall deductible	$2500
Specialist *[cost sharing]*	25%
Hospital (facility) *[cost sharing]*	25%
Other *[cost sharing]*	25%

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	**$7540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2500
Copayments	$0
Coinsurance	$1260
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3760**

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

The plan's overall deductible	$2500
Specialist *[cost sharing]*	25%
Hospital (facility) *[costsharing]*	25%
Other *[cost sharing]*	25%

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	**$5400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2500
Copayments	$0
Coinsurance	$725
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3255**

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

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

The plan's overall deductible	$2500
Specialist *[cost sharing]*	25%
Hospital (facility) *[cost sharing]*	25%
Other *[cost sharing]*	25%

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	**$1900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1900**

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