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.gabankers.com/GBAIT/gbaithome.asp. 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 and download the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-877-380-0193 to request a copy

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** /person **$4,500** /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, In-network preventive care, home health care, skilled nursing, telemedicine (Wellview only), hospice and prescription drugs.	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?	**$5,000** person/**$10,000** family for medical expenses; **$7,350** per person/**$14,700** family for medical and RX expenses combined.	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?	Premiums, balance-billed charges, pre-authorization penalties, charges over maximum allowed amount, products and services plan doesn't cover, cost of brand name drug in excess of generic drug.	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.anthem.com or call 1-877-380-0193 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 **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	$40 copay/visit	40% coinsurance	None
	Specialist visit	$50 copay/visit	40% coinsurance	None
	Preventive care/screening/ immunization	No cost	40% coinsurance; deductible waived for children under 6 years.	Covered services based on age, gender and other factors. 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)	20% coinsurance	40% coinsurance	Prior authorization may be required under some circumstances
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior Authorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com .	Generic drugs	Copay per prescription Retail $15 Mail order $30	40% coinsurance plus difference between charge and negotiated rate	Retail covers up to a 30-day supply. Mail orders cover up to a 90-day supply for generic and preferred brand; 30 days for non-preferred brand drugs. Maximum benefit for ulcer drugs: $30 Antihistamine $20 When generic equivalent available, member pays brand name copay plus difference in cost of generic and brand name drug. Step therapy required for certain drugs.
	Preferred brand drugs	Copay per prescription Retail $45 Mail order $90	40% coinsurance plus difference between charge and negotiated rate	
	Non-preferred brand drugs	Copay per prescription Retail $70 Mail order $70	40% coinsurance plus difference between charge and negotiated rate	
	Specialty drugs	20% coinsurance up to $500 per prescription per month	Not covered	Magellan Rx is exclusive provider. Not covered unless prior authorization obtained. Some drugs require enrollment in Select Drugs and Products Program. Step therapy required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior authorization required
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior authorization required

[* For more information about limitations and exceptions, see the plan or policy document at www.gabankers.com/GBAIT/gbaithome.asp

If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Not covered if not a medical emergency.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Not covered if not a medical emergency.
	Urgent care	$60 copay/visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance e`	40% coinsurance	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/office visit, 20% coinsurance other outpatient services	40% coinsurance	Some outpatient services require prior authorization. Intensive outpatient and partial hospitalization subject to same limits as home health care.
	Inpatient services	20% coinsurance	40% coinsurance	Prior authorization required. Residential treatment facilities subject to same limits as skilled nursing and medical rehab facilities.
If you are pregnant	Office visits	$50 copay first office visit, then 20% coinsurance	40% coinsurance	Not covered for dependents other than the spouse except as provided in preventive care. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No cost for first 15 visits per calendar year, then 20% coinsurance, deductible waived	40% coinsurance Deductible waived	Maximum visits: 40 per calendar year. Prior authorization required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Cardiac and pulmonary rehab requires prior authorization and individual case management. Maximum visits: 20 per calendar for physical and occupational therapy and skeletal adjustment, combined; 20 visits per year for speech therapy;
	Habilitation services	20% coinsurance	40% coinsurance	Generally, not covered. Benefits only for certain severe developmental delay.

	Skilled nursing care	No cost for first 10 days per calendar year, then 20% coinsurance, deductible waived	40% coinsurance Deductible waived	Maximum days: 60 per calendar year. Prior authorization required
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior authorization required
	Hospice services	No cost	40% coinsurance Deductible waived	Prior authorization required
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Annual screening covered under preventive care.
	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.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult)
- Habilitative Care
- Hearing Aid
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. unless prior authorization obtained
- Routine eye care
- 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, limit 20 visits per year combined with physical and occupational therapy
- Private Duty Nursing when ICU or CCU is not available
- Weight loss Programs, limited to Specialized Solutions Programs

[* For more information about limitations and exceptions, see the plan or policy document at www.gabankers.com/GBAIT/gbaithome.asp

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: Dept. of Labor 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: Paragon Benefits, Inc. at 1-800-277-9218 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. .

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-277-9218

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-277-9218

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-277-9218

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-277-9218

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** **$1500**
- **Specialist *[cost sharing]*** ***Copays & 20%***
- **Hospital (facility) *[cost sharing]*** ***20%***
- **Other *[cost sharing]*** ***$60***

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	**$12731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$65
Coinsurance	$1970.60
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3595.60**

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

- **The plan's overall deductible** **$1500**
- **Specialist *[cost sharing]*** ***Copays & 20%***
- **Hospital (facility) *[cost sharing]*** ***20%***
- **Other *[cost sharing]*** ***$55***

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	**$7389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$740
Coinsurance	$45.60
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2340.60**

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

- **The plan's overall deductible** **$1500**
- **Specialist *[cost sharing]*** ***Copays & 20%***
- **Hospital (facility) *[cost sharing]*** ***20%***
- **Other *[cost sharing]*** ***$0***

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	**$1925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$100
Coinsurance	$20.40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1620.40**

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