2014 SUPPLEMENT

The following information is provided for the 2014 Plan Year:

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

GBAIT: PPO 280

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/1/2014 – 12/31/2014

Coverage for: Individual + Family| **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.gabankers.com/GBAIT/gbaithome.asp or by calling 1-877-380-0193.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750** person **/$2250** family Doesn't apply to in-network preventive, home health, hospice, skilled nursing care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$200/** person for name brand prescription drugs when generics available. 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.
Is there an out–of–pocket limit on my expenses?	Yes. **$4,250** per person/ **$8,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, prescription drug costs, balance-billed charges, pre-authorization penalties, charges over maximum allowed amount, services plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan

plan doesn't cover?		document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in- network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	——————none——————
	Specialist visit	20% coinsurance	40% coinsurance	——————none——————
	Other practitioner office visit	20% coinsurance for skeletal adjustment	40% coinsurance for skeletal adjustment	20 visit per year maximum, combined with physical and occupational therapy
	Preventive care/screening/immunization	No charge	40% coinsurance; no deductible for children under 6yrs	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Not covered unless prior authorization obtained

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.partnersrx.com.	Generic drugs	Copay per prescription: $15 retail, $30 mail order	40% coinsurance plus difference between charge and negotiated rate	Covers up to a 30-day supply (retail), 90 day supply (mail order)
	Preferred brand drugs	Copay per prescription: $35 retail, $70 mail order	40% coinsurance plus difference between charge and negotiated rate	Covers up to a 30-day supply (retail), 90 day supply (mail order). Brand name drugs subject to specific deductible when generic equivalent available.
	Non-preferred brand drugs	Copay per prescription: $60 retail	40% coinsurance plus difference between charge and negotiated rate	Covers up to a 30-day supply (retail only). Brand name drugs subject to specific deductible when generic equivalent available
	Specialty drugs	Copay: Generic-$15/30 day supply, $30/31 to 90 day supply. Preferred brand: $35/30 day supply, $70/31 to 90 day supply. Non-preferred brand: $60/30 day supply.	40% coinsurance plus difference between charge and negotiated rate	Not covered unless prior authorization obtained. Brand name drugs subject to specific deductible when generic equivalent available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Not covered unless prior authorization obtained
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Not covered unless prior authorization obtained
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance.	For out of network provider, 40% coinsurance if not a medical emergency
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	20% coinsurance	40% coinsurance	——————none——————

If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Not covered unless prior authorization obtained
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Not covered unless prior authorization obtained
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Not covered unless prior authorization obtained
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Not covered unless prior authorization obtained
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Not covered for dependents other than spouse
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Not covered for dependents other than spouse

If you need help recovering or have other special health needs	Home health care	No cost for first 15 visits/calendar year, then 20% coinsurance, deductible waived	40% coinsurance, deductible waived	Maximum visits: 40 per calendar year. Not covered unless prior authorization obtained
	Rehabilitation services	20% coinsurance	40% coinsurance	Cardiac and pulmonary rehab requires prior authorization and individual case management. Maximum visits: 20 per calendar year 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/calendar year, then 20% coinsurance, deductible waived	40% coinsurance, deductible waived	Maximum days: 60 per calendar year. Not covered unless prior authorization obtained.
	Durable medical equipment	20% coinsurance	40% coinsurance	Not covered unless prior authorization obtained
	Hospice service	No charge	40% coinsurance, deductible waived	Not covered unless prior authorization obtained
If your child needs dental or eye care	Eye exam	No charge	40% coinsurance	Limited to one screening per year
	Glasses	Not covered	Not Covered	
	Dental check-up	Not covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. unless prior authorization obtained
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care, limited to 20 visits per year combined with physical and occupational therapy
- Private-duty nursing when ICU or CCU not available

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the GBA Insurance Trust at 404-522-1501. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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/healthreform.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,345
- **Patient pays** $2,195

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$750
Copays	$135
Coinsurance	$1310
Limits or exclusions	$0
Total	**$2,195**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,100
- **Patient pays** $1,300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$750
Copays	$180
Coinsurance	$370
Limits or exclusions	$0
Total	**$1,300**

Questions: Call **1-877-380-0193** or visit us at **www.gabankers.com/GBAIT/gbaithome.asp**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** and **www.cciio.cms.gov** or call **1-877-380-0193** to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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