

 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/gbait/home.asp](http://www.gabankers.com/GBAIT/gbait/home.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/](http://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 <a href="#">deductible</a> ?	\$1,500 /person, \$3,000 /family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, In-network preventive care, home health care, skilled nursing, telemedicine (Wellview only), hospice and prescription drugs.	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>
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,000 person/\$8,000 family for medical expenses; \$7,350 per person/\$14,700 family for medical and RX expenses combined.	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billing charges, pre-authorization penalties, charges over maximum allowed, products and services plan doesn't cover, cost of brand name drug in excess of generic drug cost	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-877-380-0193 for a list of network providers.	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 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 <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 [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)	
<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	\$40 copay/visit	Not covered	\$45 copay for after-hours visit
	<a href="#">Specialist</a> visit	\$50 copay/visit	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No cost	Not covered	Covered services based on age, gender and other factors. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your plan will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No additional cost if received in primary or specialist office visit. 20% coinsurance if at hospital or outpatient facility.	Not covered	Prior authorization may be required under some circumstances
	Imaging (CT/PET scans, MRIs)	20% coinsurance		Prior Authorization required
<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.caremark.com">www.caremark.com</a> .	Generic drugs	Copay per prescription: \$15 retail \$30 mail order	Not covered	Retail covers up to a 30-day supply. Mail orders cover up to a 90-day supply for generic and preferred brands; 30 days for non-preferred brand drugs.
	Preferred brand drugs	Copay per prescription: \$45 retail \$90 mail order	Not covered	Maximum benefit for ulcer drugs: \$30 Antihistamine \$20
	Non-preferred brand drugs	Copay per prescription: \$70 retail or mail order	Not covered	When generic equivalent available, member pays brand copay plus difference in cost of generic and brand name drug.  Step therapy required for certain drugs.
	<a href="#">Specialty drugs</a>	For drugs not included in the PrudentRx program, 20% coinsurance, up to \$500 per prescription per month. For drugs included in the Prudent Rx program, \$0 cost if you participate in the program.	Not covered	CVS Specialty is the exclusive provider. Step therapy required for certain drugs.  If you are prescribed a drug included in the PrudentRx program and you choose to opt out of the program, you will be responsible for 30% coinsurance.
<b>If you have outpatient</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Prior authorization required

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

<b>surgery</b>	Physician/surgeon fees	20% coinsurance	Not covered	Prior authorization required
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 copay/visit	\$150 copay/visit	Not covered if not a medical emergency. Copay waived if admitted to hospital.
	<a href="#">Emergency medical</a>	20% coinsurance	20% coinsurance	Not covered if not a medical emergency.
	<a href="#">Urgent care</a>	\$60 copay/visit	Not covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance`	Not covered	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	Not covered	Prior authorization required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40 copay/office visit, 20% coinsurance other outpatient services	Not covered	Some outpatient services require prior authorization.
	Inpatient services	20% coinsurance	Not covered	Prior authorization required.
<b>If you are pregnant</b>	Office visits	\$50 copay first office visit	Not covered	Not covered for dependents other than the spouse except as provided in preventive care. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% coinsurance	Not covered	Maximum visits: 120 per calendar year. Prior authorization required.
	<a href="#">Rehabilitation services</a>	\$40 copay/visit for physical, occupational speech therapy. All others: 20% coinsurance	Not covered	Cardiac and pulmonary rehab requires prior authorization and individual case management. Maximum visits: 30 per calendar year for physical and occupational therapy combined; 20 visits per year for speech therapy; respiratory therapy 40 visits.
	<a href="#">Habilitation services</a>	20% coinsurance	Not covered	Generally, not covered. Benefits only for certain severe developmental delay.
	<a href="#">Skilled nursing care</a>	20% coinsurance	Not covered	Maximum days: 30 per calendar year. Prior authorization required

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	<a href="#">Durable medical equipment</a>	20% coinsurance	Not covered	Prior authorization required
	<a href="#">Hospice services</a>	20% coinsurance	Not covered	Prior authorization required
<b>If your child needs dental or eye care</b>	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:

<b>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>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture (if prescribed for rehabilitation purposes)</li> <li>• Bariatric surgery</li> <li>• Chiropractic Care</li> <li>• Cosmetic surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Habilitative Care</li> <li>• Hearing Aid</li> <li>• Infertility Treatment</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S. unless prior authorization obtained</li> <li>• Routine eye care</li> <li>• Routine foot care</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>	
<ul style="list-style-type: none"> <li>• Private Duty Nursing when ICU or CCU is not available</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss programs, limited to Specialized Solutions Programs</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: Dept. of Labor 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: 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](http://www.dol.gov/ebsa/healthreform)

**Does this plan provide Minimum Essential Coverage?** Yes

If you don't have [Minimum Essential Coverage](#) for a month under this plan or under other coverage, 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, kwijigo 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 \[cost sharing\]](#) **Copay & 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*)

<b>Total Example Cost</b>	<b>\$12731</b>
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**In this example, Peg would pay:**

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

### 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 \[cost sharing\]](#) **Copay & 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*)

<b>Total Example Cost</b>	<b>\$7389</b>
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**In this example, Joe would pay:**

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

### Mia's Simple Fracture

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

- The [plan's overall deductible](#) **\$1500**
- [Specialist \[cost sharing\]](#) **Copay & 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*)

<b>Total Example Cost</b>	<b>\$1925</b>
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**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$829
Copayments	\$370
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1199.00</b>