




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, <https://eoc.anthem.com/eocdps/A5K7IND01012024>. 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 [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (855) 738-6652 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <a href="#">deductible</a> ?                                | \$1,200/person or \$2,400/family for In- <a href="#">Network Providers</a> .   | Generally, you must pay all of the costs from <a href="#">providers</a> 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> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Primary Care. <a href="#">Specialist Visit</a> . <a href="#">Preventive Care</a> . Certain <a href="#">Prescription Drugs</a> . Vision. For more information see below.   | 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 <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$9,450/person or \$18,900/family for In- <a href="#">Network Providers</a> .  | 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> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.   | 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/find-care/?alphaprefix=Y2W">www.anthem.com/find-care/?alphaprefix=Y2W</a> or call (855) 738-6652 for a list of <a href="#">network providers</a> . Costs may vary by site of service and how the <a href="#">provider</a> bills. | 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 <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> ? | Yes. | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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   |
|---|---|---|--|--|--|
|   |   | Level 1 Pharmacy- RX Only (You will pay the least)  | In-Network Provider (You will pay more)  | Non-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                          | Not Applicable  | Lower Copay PCP \$5/visit <a href="#">deductible</a> does not apply<br>Standard Copay PCP \$30/visit <a href="#">deductible</a> does not apply | Not covered                                  | Virtual visits (Telehealth) benefits available.  |
|   | <a href="#">Specialist</a> visit  | Not Applicable  | \$55/visit <a href="#">deductible</a> does not apply   | Not covered                                  | Virtual visits (Telehealth) benefits available.  |
|   | <a href="#">Preventive care</a> / <a href="#">screening</a> /immunization | Not Applicable  | No charge  | Not covered                                  | 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 <a href="#">plan</a> will pay for.  |
| If you have a test  | <a href="#">Diagnostic test</a> (x-ray, blood work)                       | Not Applicable  | 20% <a href="#">coinsurance</a>  | Not covered                                  | -----none-----   |
|   | Imaging (CT/PET scans, MRIs)  | Not Applicable  | \$200/visit then 35% <a href="#">coinsurance</a>   | Not covered                                  | -----none-----   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com">http://www.anthem.com</a> | Generic drugs (Tier 1)  | \$5/prescription, <a href="#">deductible</a> does not apply (retail) and \$15/prescription, <a href="#">deductible</a> does not apply (home delivery) | \$20/prescription, <a href="#">deductible</a> does not apply (retail only)   | Not covered (retail and home delivery)       | For more information, refer to "Select Drug List" at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a><br>*See Prescription Drug section |
|   | Preferred brand drugs (Tier 2)  | \$40/prescription, <a href="#">deductible</a> does not  | \$50/prescription, <a href="#">deductible</a> does not   | Not covered (retail and home delivery)       |  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/A5K7IND01012024>.

| Common Medical Event  | Services You May Need                            | What You Will Pay  |  |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|--|---|
|   |  | Level 1 Pharmacy- RX Only (You will pay the least)   | In-Network Provider (You will pay more)  | Non-Network Provider (You will pay the most)             |   |
| <a href="#">m.com/pharmacyinformation/</a>                                |  | apply (retail) and \$120/prescription, <a href="#">deductible</a> does not apply (home delivery) | apply (retail only)  |  |   |
|   | Non-preferred brand drugs (Tier 3)               | 35% <a href="#">coinsurance</a> (retail and home delivery)                                       | 45% <a href="#">coinsurance</a> (retail only)  | Not covered (retail and home delivery)                   |   |
|   | <a href="#">Specialty drugs</a> (Tier 4)         | 40% <a href="#">coinsurance</a> (retail and home delivery)                                       | 50% <a href="#">coinsurance</a> (retail only)  | Not covered (retail and home delivery)                   |   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | Not Applicable   | 20% <a href="#">coinsurance</a>  | Not covered  | -----none-----  |
|   | Physician/surgeon fees                           | Not Applicable   | 20% <a href="#">coinsurance</a>  | Not covered  | -----none-----  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | Not Applicable   | \$750/visit then 20% <a href="#">coinsurance</a>   | Covered as In- <a href="#">Network</a>                   | <a href="#">Copayment</a> waived if admitted.   |
|   | <a href="#">Emergency medical transportation</a> | Not Applicable   | 20% <a href="#">coinsurance</a>  | Covered as In- <a href="#">Network</a>                   | Non-emergency Non- <a href="#">Network</a> Ambulance Services are limited to \$50,000 per occurrence.                       |
|   | <a href="#">Urgent care</a>                      | Not Applicable   | \$50/visit <a href="#">deductible</a> does not apply   | Covered as In- <a href="#">Network</a>                   | -----none-----  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | Not Applicable   | \$500/admission then 20% <a href="#">coinsurance</a>   | Not covered  | 60 days/year for Inpatient rehabilitation and skilled nursing services combined for In- <a href="#">Network Providers</a> . |
|   | Physician/surgeon fees                           | Not Applicable   | 20% <a href="#">coinsurance</a>  | Not covered  | -----none-----  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Not Applicable   | Office Visit 20% <a href="#">coinsurance</a><br>Other Outpatient 20% <a href="#">coinsurance</a> | Office Visit Not covered<br>Other Outpatient Not covered | Office Visit<br>Virtual visits (Telehealth) benefits available.<br>Other Outpatient<br>-----none-----                       |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/A5K7IND01012024>.

| Common Medical Event   | Services You May Need                     | What You Will Pay                                  |  |  | Limitations, Exceptions, & Other Important Information  |
|--|---|--|--|--|---|
|  |   | Level 1 Pharmacy- RX Only (You will pay the least) | In-Network Provider (You will pay more)              | Non-Network Provider (You will pay the most) |   |
|  | Inpatient services                        | Not Applicable                                     | \$500/admission then 20% <a href="#">coinsurance</a> | Not covered                                  | -----none-----  |
| If you are pregnant  | Office visits                             | Not Applicable                                     | 20% <a href="#">coinsurance</a>                      | Not covered                                  | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                            |
|  | Childbirth/delivery professional services | Not Applicable                                     | 20% <a href="#">coinsurance</a>                      | Not covered                                  |   |
|  | Childbirth/delivery facility services     | Not Applicable                                     | \$500/admission then 20% <a href="#">coinsurance</a> | Not covered                                  |   |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | Not Applicable                                     | 20% <a href="#">coinsurance</a>                      | Not covered                                  | 120 visits/year In- <a href="#">Network Providers</a> .   |
|  | <a href="#">Rehabilitation services</a>   | Not Applicable                                     | 20% <a href="#">coinsurance</a>                      | Not covered                                  | *See Therapy Services section.  |
|  | <a href="#">Habilitation services</a>     | Not Applicable                                     | 20% <a href="#">coinsurance</a>                      | Not covered                                  |   |
|  | <a href="#">Skilled nursing care</a>      | Not Applicable                                     | 20% <a href="#">coinsurance</a>                      | Not covered                                  | 60 days/year for Inpatient rehabilitation and skilled nursing services combined for In- <a href="#">Network Providers</a> . |
|  | <a href="#">Durable medical equipment</a> | Not Applicable                                     | 20% <a href="#">coinsurance</a>                      | Not covered                                  | *See <a href="#">Durable Medical Equipment</a> Section  |
|  | <a href="#">Hospice services</a>          | Not Applicable                                     | 20% <a href="#">coinsurance</a>                      | Not covered                                  | -----none-----  |
| If your child needs dental or eye care                         | Children's eye exam                       | Not Applicable                                     | No charge  | Not covered                                  | *See Vision Services section  |
|  | Children's glasses                        | Not Applicable                                     | No charge  | Not covered                                  |   |
|  | Children's dental check-up                | Not Applicable                                     | 0% <a href="#">coinsurance</a>                       | Not covered                                  | *See Dental Services section  |

#### 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](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Long-term care
- Acupuncture
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Bariatric surgery
- Infertility treatment
- Private-duty nursing
- Weight loss programs

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/A5K7IND01012024>.

- Routine eye care (Adult)
- Routine foot care unless [medically necessary](#)

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

- Hearing aids 1 item(s)/ear every 48 months for children 18 years of age or under. \$3,000 maximum/hearing aid.
- Spinal Manipulation 20 visits/year

**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: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx), or contact Anthem at the number on the back of your ID card. 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 on how 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:

ATTN: Grievances and Appeals, P.O. Box 105449, Atlanta, GA 30548-5449

Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx)

**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 the Minimum Value Standards? Not Applicable.**

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](#).

*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> | \$1,200 |
| ■ <a href="#">Specialist copayment</a>                          | \$55    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

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 | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| <a href="#">Cost Sharing</a> |         |
|------------------------------|---------|
| <a href="#">Deductibles</a>  | \$1,200 |
| <a href="#">Copayments</a>   | \$10    |
| <a href="#">Coinsurance</a>  | \$2,300 |
| <i>What isn't covered</i>    |         |
| Limits or exclusions         | \$60    |
| The total Peg would pay is   | \$3,570 |

### 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> | \$1,200 |
| ■ <a href="#">Specialist copayment</a>                          | \$55    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

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 | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| <a href="#">Cost Sharing</a> |         |
|------------------------------|---------|
| <a href="#">Deductibles</a>  | \$100   |
| <a href="#">Copayments</a>   | \$1,500 |
| <a href="#">Coinsurance</a>  | \$0     |
| <i>What isn't covered</i>    |         |
| Limits or exclusions         | \$20    |
| The total Joe would pay is   | \$1,620 |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,200 |
| ■ <a href="#">Specialist copayment</a>                          | \$55    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

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 | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| <a href="#">Cost Sharing</a> |         |
|------------------------------|---------|
| <a href="#">Deductibles</a>  | \$1,200 |
| <a href="#">Copayments</a>   | \$200   |
| <a href="#">Coinsurance</a>  | \$300   |
| <i>What isn't covered</i>    |         |
| Limits or exclusions         | \$0     |
| The total Mia would pay is   | \$1,700 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 738-6652

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 738-6652 ይደውሉ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 738-6652.

**Armenian (հայերեն):** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 738-6652:

**Bassa (Bàsɔ̀ Wùdù):** M̐ dyi dyi-diè-djé bɛ́ bédé b́á céè-djé nià kɛ dyí ní, ɔ̀ m̀ò nì dyí-bédjè̀n-djé bɛ́ m̐ kɛ́ gbo-kpá-kpá kè b̐́ kp̐́ djé m̐ b́ídjí-wùdù̀ùn b́ó pídyi. Bɛ́ m̐ kɛ́ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ́, d́á (855) 738-6652.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 738-6652 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 738-6652 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 738-6652。

**Dinka (Dinka):** Na n̄ɔŋ thiëc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te k̄or yin ba jam wēnē ran ye thok geryic, ke yin c̄ol (855) 738-6652.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 738-6652.

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 738-6652 تماس بگیرید.

## Language Access Services:

**French (Français) :** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 738-6652.

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दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 738-6652

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