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 https://gabankers.com/WCM/Insurance___Retirement/Group_Benefit_Plans/Medical_Plans/WCM/Insurance___Retirement/GBA_Insurance_Trust/Medical_Plans.aspx?hkey=9c8bf693-e8a0-4844-8adc-b750613a9582 . 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 706-321-0209 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers services without a deductible, but a copayment or coinsurance may apply.
Are there other deductibles for specific services?	**No**	You don't have to meet the deductible for specific services.
What is the out-of-pocket limit for this plan?	**$3,000** person/**$6,000** 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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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 cost	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 706-321-0209 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	$25 copay/visit	Not covered	$30 copay for after-hours visit
	Specialist visit	$50 copay/visit	Not covered	None
	Preventive care/screening/ immunization	No cost	Not covered	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)	For blood work, no cost. For x-ray, 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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.judi.health/solutions/pharmacy-benefits-manager.	Generic drugs	Copay per prescription: $15 retail for 30 days $30 retail for 31-90 days $30 mail order	Not covered	Retail covers up to a 90-day supply. Mail orders cover up to a 90-day supply for generic and preferred brands; 30 days for non-preferred brand drugs. Maximum monthly benefit for: Ulcer drugs: $30 Antihistamine $20 When generic equivalent available, member pays brand copay plus difference in cost of generic and brand name drug. Step therapy required for certain drugs.
	Preferred brand drugs	Copay per prescription: $45 retail $90 mail order	Not covered	
	Non-preferred brand drugs	Copay per prescription: $70 retail or mail order	Not covered	
	Specialty drugs	For drugs not included in the Rx Cap program, 20% coinsurance, up to $500 per prescription per month. For drugs included in the RX Cap program, $0 cost if you participate in the program.	Not covered	Step therapy required for certain drugs.

[* For more information about limitations and exceptions, see the plan or policy document at https://www.gabankers.com/WCM/WCM/Insurance___Retirement/Group_Benefit_Plans.aspx?hkey=7f39cf33-8d47-4dfb-86b5-94767ea16d3d

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Prior authorization required
	Physician/surgeon fees	$250 copay/visit and 20% coinsurance	Not covered	Prior authorization required
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Not covered if not a medical emergency. Copay waived if admitted to hospital.
	Emergency medical	20% coinsurance	20% coinsurance	Not covered if not a medical emergency.
	Urgent care	$60 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/visit and 20% coinsurance`	Not covered	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit, 20% coinsurance other outpatient services	Not covered	Some outpatient services require prior authorization.
	Inpatient services	$500 copay/visit and 20% coinsurance	Not covered	Prior authorization required.
If you are pregnant	Office visits	$50 copay first office visit	Not covered	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; no coinsurance applied to physician charges for delivery	Not covered	
	Childbirth/delivery facility services	$500 copay/visit and 20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Maximum visits: 120 per calendar year. Prior authorization required.
	Rehabilitation services	$25 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 therapy; 20 visits each per year for: speech therapy; respiratory therapy, occupational therapy, and chiropractic care
	Habilitation services	20% coinsurance	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	Maximum days: 30 per calendar year. Prior authorization required
	Durable medical equipment	20% coinsurance	Not covered	Prior authorization required

[* For more information about limitations and exceptions, see the plan or policy document at https://www.gabankers.com/WCM/WCM/Insurance___Retirement/Group_Benefit_Plans.aspx?hkey=7f39cf33-8d47-4dfb-86b5-94767ea16d3d

	Hospice services	20% coinsurance	Not covered	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
- 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, except for diabetic foot

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

- Private Duty Nursing when ICU or CCU is not available. Prior authorization required.
- Weight loss programs, limited to Specialized Solutions Programs

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: GBAIT at 706-321-0209 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

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? 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 706-321-0209

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 706-321-0209

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 706-321-0209

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 706-321-0209

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

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[* For more information about limitations and exceptions, see the plan or policy document at https://www.gabankers.com/WCM/WCM/Insurance___Retirement/Group_Benefit_Plans.aspx?hkey=7f39cf33-8d47-4dfb-86b5-94767ea16d3d

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 $0
- Specialist *[cost sharing]* *Copays & 20%*
- Hospital (facility) *[cost sharing]* *Copays & 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	$0
Copayments	$565
Coinsurance	$2170.60
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2795.60**

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

- The plan's overall deductible $0
- Specialist *[cost sharing]* *Copays &20%*
- Hospital (facility)*[cost sharing]* *Copays &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	$0
Copayments	$680
Coinsurance	$345.60
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1080.60**

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

- The plan's overall deductible $0
- Specialist *[cost sharing]* *Copay & 20%*
- Hospital (facility)*[cost sharing]* *Copay &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	$0
Copayments	$275
Coinsurance	$165.80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$440.80**

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