This is only a summary of pharmacy benefits. You also have valuable medical benefits that are described in the applicable Gold, Silver or Bronze medical benefits summary ("Medical SBC"). You should read this summary (the "Pharmacy SBC") and the Medical SBC together. If you want more detail about your coverage and costs, you can get the complete terms by visiting the Plan Documents page of the DCH website: www.dch.georgia/shbp. For assistance with pharmacy benefits, you may call 1-877-841-5227.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for prescription drugs. Your costs will first be paid with available HRA dollars. The amount paid from your HRA Account, or paid out-of-pocket, will not count toward your medical benefits **deductible**. See the Medical SBC and the Plan Documents for more information.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for prescription drugs.
Is there an out–of–pocket limit on my expenses?	No, there is no **out-of-pocket limit** on your prescription expenses. **Coinsurance** maximums, the **coinsurance** waiver program, and the HRA Account can reduce your out-of-pocket expenses.	Because there is no **out-of-pocket limit**, there's no limit on how much you could pay during a coverage period for your share of the cost of prescription drugs. Instead, for every prescription there is a maximum amount you will pay in **coinsurance** for that prescription. See the chart starting on page 2 for the **coinsurance** maximums. For information about the **coinsurance** waiver program operated by BlueCross BlueShield of Georgia, see the Plan Documents or call the toll-free number on the back of your SHBP ID card. For information about your HRA Account and how you can earn extra HRA dollars, see the Medical SBC.
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.
Does this plan use a network of providers?	Yes. Call the toll-free number on the back of your SHBP ID card for a list of participating **providers** or go to www.express-scripts.com/georgiashbp.	If you use an in-network pharmacy, this plan will pay some or all of the costs of covered 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?	Not applicable.	Not applicable.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services.**

- **Coinsurance** 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 a preferred brand prescription drug is $100, your **coinsurance** payment of 25% would be $25.
- 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 will pay the entire cost and submit a paper claim. The plan will reimburse you based on the allowed amount.

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	See Medical SBC		
	Specialist visit	See Medical SBC		
	Other practitioner office visit	See Medical SBC		
	Preventive care/screening/immunization	See Medical SBC		
If you have a test	Diagnostic test (x-ray, blood work)	See Medical SBC		
	Imaging (CT/PET scans, MRIs)	See Medical SBC		

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com/georgiashbp	Generic drugs	15% **coinsurance**, with $20 min/$50 max (31 day supply) Prescription drugs identified in Plan Documents as "preventive" – no **coinsurance**.	Same coinsurance and min/max as for In-network, but based on the **allowed amount.** You must pay out of pocket and submit a paper claim for reimbursement. The plan will reimburse you based on the **allowed amount** for in-network pharmacies.	For non-maintenance medication, there is a 31 day supply limit at retail pharmacies. Maintenance medications can be filled for up to a 90 day supply (retail or home delivery). For 32 – 62 day supply – monthly min/max is doubled 63 – 90 day supply – monthly min/max is tripled 90-day supply at 90 day supply retail pharmacy, monthly min/max is multiplied by 2.5 1-90 day supply through home delivery, monthly min/max is multiplied by 2.5 See www.express-scripts.com/georgiashbp for maintenance medications, the Preferred Drug List, and to find 90-day network pharmacies (pharmacy locator link). See the Plan Documents for a list of drugs that require prior authorization or have other limits, to see a list of drugs identified as "preventive," to see the definition of coinsurance minimum and maximum, and to see examples.
	Preferred brand drugs	25% coinsurance, $50 min/$80 max (31 day supply) Prescription drugs identified in Plan Documents as "preventive," and for which no generic is available or which must be dispensed as written – no **coinsurance**	Same as above	

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
	Non-preferred brand drugs	25% coinsurance, $80 min/$125 max (31 day supply) Prescription drugs identified in Plan Documents as "preventive," and for which no generic is available or which must be dispensed as written – no **coinsurance**	Same as above	Drugs identified as specialty drugs under the Preferred Drug List must be filled at Express Scripts specialty pharmacy, Accredo. One courtesy fill is allowed at retail before these prescriptions are required to be filled at Accredo. If you choose to continue to fill your specialty drug after that one courtesy fill at your retail pharmacy, then you will pay the full price out of pocket and will not be reimbursed by the plan. If you purchase a brand-name drug when a generic equivalent is available, you will pay the generic coinsurance payment, *plus* the difference in cost between the brand and the generic.
	Specialty drugs	See the applicable **coinsurance** above, depending on whether the specialty drug is generic, preferred brand or non-preferred brand.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See Medical SBC		
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services			
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fee			

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	See Medical SBC		
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care			
	Delivery and all inpatient services			
If you need help recovering or have other special health needs	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	Eye exam			
	Glasses			
	Dental check-up			

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.)

- Drugs dispensed by a hospital during an in-patient confinement
- Drugs prescribed to treat infertility
- Most drugs that are covered as a medical benefit
- Over the counter (OTC) drugs, except those identified as "preventive" in Plan Documents
- Prescription drugs with an OTC equivalent
- Experimental drugs

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.)

- Drugs approved for US distribution by FDA
- Prescription Contraceptives
- Insulin when prescribed by a physician

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 plan at 1 800-610-1863. 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 ext. 61565 or www.cciio.com.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**. You should contact the appropriate health care vendor directly to appeal denial of coverage for claims. See the Plan Documents, or call the appropriate phone number on your SHBP ID card. Pharmacy benefits – contact Express Scripts, Inc., Coinsurance waiver program - Blue Cross Blue Shield of Georgia, Healthways, Inc. - eligibility for Nicotine Replacement Therapy. For questions about your eligibility, rights, this notice, or assistance, you can contact 1-800-610-1863 or access information about eligibility appeals at www.dch.georgia.gov/shbp.

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." **The plan, which includes medical and well-being benefits described in the medical SBC and pharmacy benefits described in this pharmacy SBC 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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-641-4862.

To see examples of how this plan might cover costs for a sample medical situation, see the coverage examples in the Medical SBC.