



This is only a summary. You also have valuable medical benefits that are described in the applicable HDHP 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.gov/shbp. For assistance with pharmacy benefits, you may call 1-877-841-5227.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	In-Network You: \$3,500 In-Network You +spouse or child(ren): \$7,000 In-Network You + Family: \$7,000 Out-of-Network You: \$7,000 Out-of- Network You + spouse or child(ren): \$14,000 Out-of-Network You + Family: \$14,000	See the chart starting on page 3 for your costs for prescription drugs. See the Medical SBC and the Plan Documents for more information.
Are there other <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses?	In-Network You Only: \$6,450 In-Network You + spouse or child: \$12,900 In-Network You + Family: \$12,900 Out-of-Network You: \$12,900 Out-of-Network You + spouse or child: \$25,800 Out-of-Network You + Family: \$25,800	There is a limit on how much you could pay during a coverage period for your share of the cost of prescription drugs. Once you’ve reached your out-of-pocket maximum, including your deductible , your plan pays 100 percent of eligible medical and prescription drug expenses for the remainder of the benefit year. Please note that both the medical and pharmacy claims are combined and count toward your out-of-pocket.
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 <i>specific</i> covered services.
Does this plan use a <u>network of providers</u>?	Yes. Call the toll-free number on the back of your Member 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 <u>specialist</u>?	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 .

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- **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** a preferred brand prescription drug is \$100, your **coinsurance** payment of 20% would be \$20.
- 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			
	Other practitioner office visit			
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
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	30% coinsurance after deductible is met. Prescription drugs identified in Plan Documents as "preventive" – no coinsurance .	Same coinsurance 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). See www.express-scripts.com/georgiaSHBP for maintenance medications, the Preferred Drug List, and to find 90-day retail network pharmacies (pharmacy locator link).

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
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.express-scripts.com/georgiaSHBP</p>	Preferred brand drugs	30% coinsurance after deductible is met. 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	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,” and to see examples. 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 by 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 co-insurance payment, <i>plus</i> the difference in cost between the brand and the generic. This differential will not apply towards your out-of-pocket maximums.
	Non-preferred brand drugs	30% coinsurance after deductible is met. 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	
	Specialty drugs	30% coinsurance after deductible is met	30% coinsurance after deductible is met	

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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	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	
	Mental/Behavioral health inpatient services	
	Substance use disorder outpatient services	
	Substance use disorder inpatient services	
If you are pregnant	Prenatal and postnatal care	See Medical SBC
	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	

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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 the 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 for more information, or call the appropriate phone number on your Member ID card. For questions about your eligibility, rights, this notice, or assistance, you can contact: the State Health Benefit Plan Call Center at 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.**

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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.*—————

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