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Exchange Notice
Health Care Reform

DOL Releases Long-awaited Exchange Notice, Updates COBRA Model Notice

On May 8, 2013, the U.S. Department of Labor (DOL) updated its Web page with Technical Release 2013-02, which includes temporary guidance on the notice to employees of coverage options (known as the "Exchange Notice") required under the Patient Protection and Affordable Care Act (PPACA), commonly known as health care reform. The temporary guidance also included frequently asked questions (FAQs) about the notice requirement.

As background, PPACA requires that applicable employers provide each employee with a written notice providing information about the exchange (also referred to as "marketplaces") and how to request assistance, describing the availability of a premium tax credit and outlining the implications for the employee if they choose to purchase a qualified health plan through an exchange. The law required employers to distribute the notice by March 1, 2013. However, on Jan. 24, 2013, the DOL announced that the Exchange Notice requirement was delayed until summer or fall 2013, so that the distribution deadline would coincide with the open enrollment period for the health insurance exchanges. In a surprise announcement, the DOL has provided this temporary guidance earlier than previously announced, so employers can now inform their employees about the upcoming coverage options available through the exchanges.

At the same time, the DOL also released a revised version of the COBRA Election Notice. The changes incorporate references to the exchanges as well as eligibility for premium tax credits. Finally, the revised COBRA Election Notice clarifies that pre-existing conditions will not be taken into account beginning in 2014.

Covered Employers

All employers covered under the Fair Labor Standards Act (FLSA) are subject to the Exchange Notice requirement. The DOL's Wage and Hour Division provides an Internet compliance assistance tool to determine if an employer is subject to FLSA. See www.dol.gov/elaws/esa/flsa/scope/screen24.asp.

Regarding the COBRA notice, all private-sector group health plans maintained by employers that have at least 20 employees on more than 50 percent of its typical business days in the previous calendar year are subject to COBRA and may use this notice. Both full-time and part-time employees are counted to determine whether a plan is subject to COBRA, as well as any controlled group or affiliated service group associated with the employer.

Effective Date

Based on this temporary guidance, it is now clear that the deadline for employers to distribute the Exchange Notice to employees is Oct. 1, 2013. Additionally, employers are required to provide the notice to each new employee hired on or after Oct. 1, 2013, no later than 14 days after the employee's start date. The notice must be distributed to all new employees, regardless of their eligibility for coverage under the employer's group health plan, and regardless of whether the employee is full-time or part-time. Employers not offering group health plan coverage must also provide the notice. The DOL clarified that employers are permitted to use the model notice and rely on the temporary guidance prior to the Oct. 1, 2013, applicability date if they wish to do so.

Concerning the COBRA notice, use of the newest model election notice, appropriately completed, will be considered by the DOL to be good faith compliance with the election notice content requirements of COBRA.

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Model Notices

Technical Release 2013-02 contains a model Exchange Notice for employers that offer coverage to some or all employees, and a separate model notice for employers that do not offer coverage to employees.

- A model notice for employers that offer a health plan to some or all employees is available at www.dol.gov/ebsa/pdf/FLSAwithplans.pdf.
- A model notice for employers that do not offer a health plan is available at www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf.
- The COBRA model Election Notice is available at www.dol.gov/ebsa/modelelectionnotice.doc.
- The COBRA model Election Notice redlined to show May 2013 changes is available at www.dol.gov/ebsa/modelelectionnoticeredline.doc.

Additional Resources

Technical Release 2013-02 (Including FAQs): www.dol.gov/ebsa/newsroom/tr13-02.html

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)	
Douglas County School System		
5. Employer address	6. Employer phone number	
9030 Hwy 5	770-651-2000	
7. City	8. State	9. ZIP code
Douglasville	GA	30134
10. Who can we contact about employee health coverage at this job?		
Stephanie Groover		
11. Phone number (if different from above)	12. Email address	
770-651-2378	Stephanie.Groover@douglas.k12.ga.us	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    Employees that meet the eligibility provisions established in Ga. Comp. R. & Regs. Section 111-4-1-.04 and as set forth in the SHBP statutes governing the Plan, O.C.G.A. Section 45-18-1, O.C.G.A. Section 20-2-881, and O.C.G.A. 20-2-911.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    (1) legally married spouse, as defined by Georgia law; (2) natural or legally adopted children or stepchildren, under the age 26; (3) other children under 26; (4) natural children, legally adopted children or stepchildren 26 or older from categories 2 and 3 above who are physically or mentally disabled prior to age 26, and are primarily dependent on the Enrolled member for support and maintenance
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

    ☐ **Yes** (Continue)
    13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
    ☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
    ☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
    a. How much would the employee have to pay in premiums for this plan? $_____
    b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
    ☐ Employer won't offer health coverage
    ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
    a. How much would the employee have to pay in premiums for this plan? $_____
    b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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What Health Care Reform Means for Me

A Summary of 2014 Impacts on Employees

May 2013

The impact of health care reform on employees in 2014 requires you to take action — enroll yourself in minimum essential coverage or pay a penalty.

The Patient Protection and Affordable Care Act, also known as health care reform or the Affordable Care Act, was enacted on March 23, 2010, and has been amended many times already. In its current form, the law has resulted in a steady stream of regulations and guidance as various governmental entities clarified employers' requirements under the law over the past three years. The aspect of the legislation that will affect you as an individual is known as the individual mandate, and is effective Jan. 1, 2014. At that time, most Americans will be required to purchase health insurance coverage that meets a certain minimum standard. If such coverage is not purchased, individuals will pay an additional tax on his or her 2014 personal income tax return filed in 2015.

As your employer, we continue to implement provisions to comply with the requirements of the health care reform law. This summary focuses on the changes that affect you as an individual, as well as changes in the benefit programs we offer in 2014. We encourage you to pay careful attention to your health care benefits so you can keep up with the changes.

What coverage must I carry to avoid paying a penalty?

Nearly all Americans are required to carry "minimum essential coverage" or pay a penalty beginning in 2014. Most employer-sponsored group health insurance qualifies as minimum essential coverage, as does governmental coverage (like Medicare, Medicaid, CHIP and TRICARE), retiree coverage, COBRA coverage and individual policies. The coverage we offer you qualifies as minimum essential coverage. If you decide not to take our coverage, the penalty amount applies if you go without minimum essential coverage for at least three months in 2014 (you cannot have a gap in coverage for more than a continuous three-month period). The penalty assessed when you file your taxes will be the greater of a flat dollar amount or a percentage of income amount, illustrated in the table below.

Year	Adults in household	Children in household 18 Years or Younger	Calculated when filing taxes for the applicable year*
2014	$95	$47.50	1 %
2015	$325	$162.50	2 %
2016	$695	$347.50	2.5 %

*The penalty amount is determined by subtracting exemptions and standard deductions from household income. The resulting figure is multiplied by the percentage of income. If this figure is greater than the flat dollar amount, the taxpayer pays the percentage of income penalty.

Do I have to take the coverage my employer offers me?

No. But you should be aware that in most cases, the election you make is considered irrevocable and cannot be reversed if you change your mind. If you decide not to take employer-sponsored coverage in 2014, you should purchase coverage elsewhere, such as through a health insurance exchange, discussed next.

In some cases you could experience either a HIPAA special enrollment right or qualifying event that would allow you to enroll in our coverage midyear. Examples might include if you get married, have a baby or adopt a child midyear, qualify for premium assistance through CHIP or lose coverage (through Medicaid or another employer-sponsored plan). If the plan we offer is a non-calendar year plan, we may elect to include an optional Section 125 qualifying event to allow you to enroll or drop our coverage midyear. Importantly, not paying premiums for an individual policy or having a change in financial condition will not allow you to join our plan midyear. Ask your Human Resources representative for more information about this. In all cases, we are not permitted to retaliate against you for choosing to enroll in coverage somewhere other than our plan.

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Where can I get coverage if I do not want my employer's coverage?

The federal government and states are in the process of setting up online public health insurance exchanges. You may hear these referred to as marketplaces. There are also many private exchanges and marketplaces being formed. Some states have already created marketplaces.

Importantly, the public exchanges set up and administered by the federal government and the states will be the only avenue for qualifying employees to receive assistance with paying premiums and reducing other cost-sharing normally associated with health insurance (including deductibles, co-payments and co-insurance) in the form of advance tax credits and subsidies. These will not be available in private exchanges. Income parameters and other eligibility requirements apply to qualify for a tax credit or subsidy. To qualify for subsidies, an employee must have household income of between 100 percent and 400 percent of the federal poverty line. Plus, the cost of health insurance premiums must exceed 9.5 percent of household income.

What should I consider when deciding whether to enroll in coverage offered through my employer versus an exchange?

Employer-sponsored coverage is generally subsidized by the employer offering the coverage. This means the cost to you is most likely less than it would be if you purchased it on your own. In many cases, the amount of the employer contribution is more than the federal subsidy or tax credit that you would qualify for through a public exchange. Another reason to consider keeping employer-sponsored coverage is the tax implications of paying for coverage on your own. Coverage purchased through a public exchange cannot be paid on a pre-tax basis. However, paying for coverage offered through your employer can be done on a pre-tax basis. Depending on the amount of premiums paid and your individual effective tax rate, you may see a significant savings in your taxes by paying for employer-sponsored coverage on a pre-tax basis. Finally, allowing us, as your employer, to handle the design choices and narrow down the network of providers, as well as issue the required tax filings, can relieve you of many of the tasks that are inherent when purchasing coverage on your own.

Besides the individual mandate, what else goes into effect in 2014?

Additional major provisions will go into effect in 2014, and continue through 2018. As always, you need to be actively involved with your benefits program. Much will happen behind the scenes, but you can be assured your benefits will comply with the new laws. Other requirements that you will see going into effect in 2014 include:

- **Elimination of certain benefits limits and exclusions:** Lifetime limits on certain essential health benefits were already eliminated, and annual limits on essential health benefits are phased out in 2014. Also, individuals of any age can now obtain coverage regardless of any pre-existing health conditions (previously only applied to under age 19).
- **Cost-sharing limitations:** You may see lower deductibles or lower out-of-pocket limits on plans offered on the exchanges, as well as adjustments in our plan as we incorporate new limits.
- **Limits on waiting periods:** Once you satisfy the eligibility requirements for coverage, we must allow you to enroll in coverage no later than 90 days after becoming eligible. Enrollment in the plan on the first of the month following 90 days is no longer allowed.
- **Increases in fees and taxes:** Insurers and employers also have many other fees and taxes to pay beginning in 2014. As a result, you may see overall increases in the cost of health care from the prices you pay today.
- **Reporting:** Employers and insurers are required to report certain aspects about the coverage that is offered to you to the federal government. You will receive a copy of the reporting as well. The reporting will be necessary for the government agencies to determine your eligibility for a premium tax credit or cost-sharing subsidy.
- **Wellness incentives:** As a way to reward you for your healthy choices, the federal government is increasing the amount of wellness incentives that we are allowed to offer you. While not all employers will implement these incentives, many employers may decide to encourage healthy behaviors as an alternative to the increasing cost of health care.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.mycigna.com/shbp** or by calling 1-800-633-8519 **or** **www.myuhc.com/shbp** or by calling 1-877-246-4189.

Important Questions	Answers			Why this Matters:
What is the overall deductible?		In-network :	Out-of-network:	You must pay all negotiated costs until the deductible is satisfied before this plan begins to pay for certain covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
	• You	$ 2,000	$ 4,000	
	• You + Child(ren)	$ 4,000	$ 8,000	
	• You + Spouse	$ 4,000	$ 8,000	
	• You + Family	$ 4,000	$ 8,000	
Are there other deductibles for specific services?	No.			
Is there an out-of-pocket limit on my expenses?	Yes.			The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
		In-network :	Out-of-network:	
	• You	$ 4,500	$ 9,000	
	• You + Child(ren)	$ 9,000	$ 18,000	
	• You + Spouse	$ 9,000	$ 18,000	
	• You + Family	$ 9,000	$ 18,000	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and any non-covered services this plan doesn't cover.			Even though you may pay these expenses, they don't count toward the out-of-pocket limit.
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, such as office visits.

Questions: Call 1-800-610-1863 or visit us at **www.dch.georgia.gov/shbp** for additional information including a copy of your plan's summary plan description. If you aren't clear about any of the underlined terms used in this form, see the SBC Uniform Glossary. You can view the SBC Uniform Glossary at **www.dch.georgia.gov/shbp** or call 1-800-610-1863 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See **www.mycigna.com/shbp** or by calling 1-800-633-8519 **or www.myuhc.com/shbp** or by calling 1-877-246-4189 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting below for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without obtaining a referral from your primary care physician.
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.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- 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 may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

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	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	None
	Specialist visit	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Other practitioner office visit	20% co-insurance for chiropractor	40% co-insurance for chiropractor	
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

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
	Imaging (CT/PET scans, MRIs)	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.dch.georgia.gov/shbp.**	Generic drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
	Preferred brand drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
	Non-preferred brand drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
	Specialty drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Physician/surgeon fees	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need immediate medical attention	Emergency room services	20% coinsurance after satisfying the in-network deductible	20% coinsurance after satisfying the in-network deductible	
	Emergency medical transportation	20% coinsurance after satisfying the in-network deductible.	20% coinsurance after satisfying the in-network deductible.	
	Urgent care	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Physician/surgeon fee	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

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	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Mental/Behavioral health inpatient services	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Substance use disorder outpatient services	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Substance use disorder inpatient services	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you are pregnant	Prenatal and postnatal care	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Delivery and all inpatient services	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Rehabilitation services (Acute Short-term Rehabilitation)	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	40 therapy visits per Plan year, in-network and out-of-network visits not to exceed 40 combined
	Habilitation services	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	40 therapy visits per Plan year, in-network and out-of-network visits not to exceed 40 combined
	Skilled nursing facility services	20% coinsurance after satisfying the deductible	No coverage	Up to 120 days per Plan year
	Durable medical equipment	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Hospice service	20% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

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 your child needs dental or eye care	Eye exam	0 cost, not subject to deductible	Not covered	One eye exam every 24 months
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

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.)		
• Routine dental care	• Cosmetic surgery	• Infertility treatment

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.)	
• Dental Coverage for prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	See the SPD at **www.dch.georgia.gov/shbp** for more information

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.

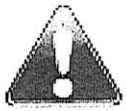
For more information on your rights to continue coverage, contact the plan at 1 800-610-1863. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human 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 your health care vendor directly to appeal denial of coverage for claims. You should contact Cigna at 800-633-8519 or www.mycigna.com/shbp or UnitedHealthcare at 877-246-4189 or www.myuhc.com/shbp. 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.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,432
- **Patient pays** $3,108

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Co-pays	$0
Co-insurance	$1,108
Limits or exclusions	$0
Total	**$3,108**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $1,680
- **Patient pays** $2,420

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$2,000
Co-pays	$0
Co-insurance	$420
Limits or exclusions	$0
Total	**$2,420**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers,** costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1- 800-610-1863 or visit us at www.dch.georgia.gov/shbp for additional information including a copy of your plan's summary plan description. If you aren't clear about any of the underlined terms used in this form, see the SBC Uniform Glossary. You can view the SBC Uniform Glossary at **www.dch.georgia.gov/shbp** or call 1-800-610-1863 to request a copy.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at.www.mycigna.com/shbp or by calling 1-800-633-8519 **or** www.myuhc.com/shbp or by calling 1-877-246-4189.

Important Questions	Answers		Why this Matters:
What is the overall deductible?	In-network :	Out-of-network:	You must pay all negotiated costs until the deductible is satisfied before this plan begins to pay for certain covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
	• You $ 1,800	$ 3,600	
	• You + Child(ren) $ 3,600	$ 7,200	
	• You + Spouse $ 3,600	$ 7,200	
	• You + Family $ 3,600	$ 7,200	
Are there other deductibles for specific services?	No.		
Is there an out-of-pocket limit on my expenses?	Yes.		The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
	In-network :	Out-of-network:	
	• You $ 4,000	$ 8,000	
	• You + Child(ren) $ 8,000	$ 16,000	
	• You + Spouse $ 8,000	$ 16,000	
	• You + Family $ 8,000	$ 16,000	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and any non-covered services this plan doesn't cover.		Even though you may pay these expenses, they don't count toward the out-of-pocket limit.
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, such as office visits.

Questions: Call 1-800-610-1863 or visit us at **www.dch.georgia.gov/shbp** for additional information including a copy of your plan's summary plan description. If you aren't clear about any of the underlined terms used in this form, see the SBC Uniform Glossary. You can view the SBC Uniform Glossary at **www.dch.georgia.gov/shbp** or call 1-800-610-1863 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See **www.mycigna.com/shbp** or by calling 1-800-633-8519 or **www.myuhc.com/shbp** or by calling 1-877-246-4189 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting below for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without obtaining a referral from your primary care physician.
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.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- 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 may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

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	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	None
	Specialist visit	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Other practitioner office visit	10% co-insurance for chiropractor	40% co-insurance for chiropractor	
	Preventive care/screening/immunization	No charge	100% of the cost - not covered	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

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
	Imaging (CT/PET scans, MRIs)	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.dch.georgia.gov/shbp.**	Generic drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
	Preferred brand drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
	Non-preferred brand drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
	Specialty drugs	20% coverage; subject to deductible $10 min/$100 max	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after satisfying the deductible	10% coinsurance after satisfying the deductible	
	Physician/surgeon fees	10% coinsurance after satisfying the deductible	10% coinsurance after satisfying the deductible	
If you need immediate medical attention	Emergency room services	10% coinsurance after satisfying the deductible	10% coinsurance after satisfying the deductible	
	Emergency medical transportation	10% coinsurance after satisfying the deductible	10% coinsurance after satisfying the deductible	
	Urgent care	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Physician/surgeon fee	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

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	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Mental/Behavioral health inpatient services	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Substance use disorder outpatient services	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Substance use disorder inpatient services	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you are pregnant	Prenatal and postnatal care	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Delivery and all inpatient services	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Rehabilitation services	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	40 therapy visits per Plan year, in-network and out-of-network visits not to exceed 40 combined
	Habilitation services	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	40 therapy visits per Plan year, in-network and out-of-network visits not to exceed 40 combined
	Skilled nursing facility	10% coinsurance after satisfying the deductible;	No coverage	Up to 120 days per Plan year
	Durable medical equipment	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Hospice service	10% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

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 your child needs dental or eye care	Eye exam	0 cost, not subject to deductible	Not covered	One eye exam every 24 months
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

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.)		
• Routine dental care	• Cosmetic surgery	• Infertility treatment

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.)	
• Dental Coverage for prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	See the SPD at **www.dch.georgia.gov/shbp** for more information

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.

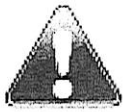
For more information on your rights to continue coverage, contact the plan at 1 800-610-1863. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human 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 your health care vendor directly to appeal denial of coverage for claims. You should contact Cigna at 800-633-8519 or www.mycigna.com/shbp or UnitedHealthcare at 877-246-4189 or www.myuhc.com/shbp. 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.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,166
- **Patient pays** $ 2,374

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,800
Co-pays	$0
Co-insurance	$574
Limits or exclusions	$0
Total	**$2,374**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $2,070
- **Patient pays** $ 2,030

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$1,800
Co-pays	$0
Co-insurance	$230
Limits or exclusions	$0
Total	**$2,030**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers,** costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mycigna.com/shbp or by calling 1-800-633-8519 **or** www.myuhc.com/shbp or by calling 1-877-246-4189.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Wellness : Standard: • You $ 1,300 $ 1,300 • You + Child(ren) $ 1,950 $ 1,950 • You + Spouse $ 1,950 $ 1,950 • You + Family $ 2,600 $ 2,600	You must pay all negotiated costs until the deductible is satisfied before this plan begins to pay for certain covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Wellness and Standard: No	
Is there an out-of-pocket limit on my expenses?	Yes. Wellness : Standard: • You $ 4,000+Copays $ 4,500+Copays • You + Child(ren) $ 6,500+Copays $ 7,000+Copays • You + Spouse $ 6,500+Copays $ 7,000+Copays • You + Family $ 9,000+Copays $ 9,500+Copays	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Wellness and Standard: Premiums, balance-billed charges, copays and any non-covered services this plan doesn't cover	Even though you may pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	Wellness and Standard: No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.

Questions: Call 1-800-610-1863 or visit us at www.dch.georgia.gov/shbp for additional information including a copy of your plan's summary plan description. If you aren't clear about any of the underlined terms used in this form, see the SBC Uniform Glossary. You can view the SBC Uniform Glossary at www.dch.georgia.gov/shbp or call 1-800-610-1863 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See **www.mycigna.com/shbp** or by calling 1-800-633-8519 or **www.myuhc.com/shbp** or by calling l-877-246-4189for a list of participating providers.	If you use an in-network doctor or other health care provider, 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?	Wellness and Standard: No	
Are there services this plan doesn't cover?	Wellness and Standard: 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.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** is used, there are no benefits and you are responsible for all charges, unless emergency.
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

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	• **Wellness :** $35 copay • **Standard:** $55 copay	Not covered	None
	Specialist visit	• **Wellness :** $45 copay • **Standard:** $65 copay	Not covered	
	Other practitioner office visit	• **Wellness :** $45 copay • **Standard:** $65 copay	Not covered	
	Preventive care/screening/immunization	Wellness and Standard: No cost	Not covered	

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 a test	Diagnostic test (x-ray, blood work)	Wellness and Standard: 20% coinsurance after satisfying the deductible	Not covered	
	Imaging (CT/PET scans, MRIs)	Wellness and Standard: 20% coinsurance after satisfying the deductible	Not covered	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.dch.georgia.gov/shbp.**	Generic drugs	Wellness and Standard: $20	Not covered	
	Preferred brand drugs	Wellness and Standard: $50	Not covered	
	Non-preferred brand drugs	Wellness and Standard: $90	Not covered	
	Specialty drugs	Wellness and Standard: Tier I: $20 Tier II: $50 Tier III: $90	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Wellness and Standard: 20% coinsurance after satisfying the deductible	Not covered	
	Physician/surgeon fees	Wellness and Standard: 20% coinsurance after satisfying the deductible	Not covered	
If you need immediate medical attention	Emergency room services	Pay 0 after $150 per visit copay for ER only. If admitted, 20% after deductible is satisfied	Not covered	Copay is waived if admitted
	Emergency medical transportation	Wellness and Standard: No cost	Not covered	
	Urgent care	• Wellness : $35 copay • Standard: $55 copay	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Wellness and Standard: 20% coinsurance after satisfying the deductible	Not covered	
	Physician/surgeon fee	Wellness and Standard: 20% coinsurance after satisfying the deductible	Not covered	

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	Wellness: 100% after $45 specialist copay Standard: 100% after $65 specialist copay	Not covered	
	Mental/Behavioral health inpatient services	Wellness and Standard: 20% coinsurance after satisfying the deductible	Not covered	
	Substance use disorder outpatient services	Wellness: 100% after $45 specialist copay Standard: 100% after $65 specialist copay	Not covered	
	Substance use disorder inpatient services	Wellness and Standard: 20% coinsurance after satisfying the deductible	Not covered	
If you are pregnant	Prenatal and postnatal care	Wellness and Standard: 20% coinsurance after satisfying the deductible	Not covered	
	Delivery and all inpatient services	Wellness and Standard: 20% coinsurance after satisfying the deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	Wellness and Standard: No cost	Not covered	UnitedHealthcare / up to 120 visits; Cigna/up to 120 days
	Rehabilitation services	• Wellness : $25 copay • Standard: $25 copay	Not covered	40 therapy visits per Plan year
	Habilitation services	• Wellness : $25 copay • Standard: $25 copay	Not covered	40 therapy visits per Plan year
	Skilled nursing care	Wellness and Standard: 20% coinsurance after satisfying the deductible	No coverage	Up to 120 days per Plan year
	Durable medical equipment	Wellness and Standard: No cost	Not covered	
	Hospice service	Wellness and Standard: No cost after satisfying the deductible	Not covered	

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 your child needs dental or eye care	Eye exam	Wellness and Standard: No cost	Not covered	One eye exam every 24 months
	Glasses	Wellness and Standard: Not covered	Not covered	
	Dental check-up	Wellness and Standard: Not covered	Not covered	

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.)		
• Routine dental care	• Cosmetic surgery	• Infertility treatment

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.)	
• Dental Coverage for prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	See the SPD at **www.dch.georgia.gov/shbp** for more information

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.

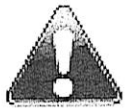
For more information on your rights to continue coverage, contact the plan at 1 800-610-1863. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human 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 your health care vendor directly to appeal denial of coverage for claims. You should contact Cigna at 800-633-8519 or www.mycigna.com/shbp or UnitedHealthcare at 877-246-4189 or www.welcometouhc.com/shbp. 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.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,000
- **Patient pays** $ 2,540

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,300
Co-pays	$40
Co-insurance	$1,200
Limits or exclusions	$0
Total	**$2,540**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $3825
- **Patient pays** $ 275

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$0
Co-pays	$275
Co-insurance	$0
Limits or exclusions	$0
Total	**$275**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1- 800-610-1863 or visit us at **www.dch.georgia.gov/shbp** for additional information including a copy of your plan's summary plan description. If you aren't clear about any of the underlined terms used in this form, see the SBC Uniform Glossary. You can view the SBC Uniform Glossary at **www.dch.georgia.gov/shbp** or call 1-800-610-1863 to request a copy.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mycigna.com/shbp or by calling 1-800-633-8519 **or** www.myuhc.com/shbp or by calling 1-877-246-4189.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-network and Out-of-network:** • You — Deductible: $ 1,600 — *HRA Credits: $ 150 • You + Child(ren) — $ 2,800 — $ 300 • You + Spouse — $ 2,800 — $ 300 • You + Family — $ 4,000 — $ 500	You must pay all negotiated costs until the deductible is satisfied, after exhausting your HRA Credits, before this plan begins to pay for certain covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. ***HRA Credits will reduce this amount.**
Are there other deductibles for specific services?	No	
Is there an out-of-pocket limit on my expenses?	**In-network and Out-of-network:** • You $ 4,500 • You + Child(ren) $ 7,000 • You + Spouse $ 7,000 • You + Family $ 9,500	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. ***HRA Credits will reduce this amount.**
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, prescription drug coinsurance and any non-covered services this plan doesn't cover	Even though you may pay these expenses, they don't count toward the out-of-pocket limit.
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, such as office visits.

Questions: Call 1-800-610-1863 or visit us at www.dch.georgia.gov/shbp for additional information including a copy of your plan's summary plan description. If you aren't clear about any of the underlined terms used in this form, see the SBC Uniform Glossary. You can view the SBC Uniform Glossary at www.dch.georgia.gov/shbp or call 1-800-610-1863 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See **www.mycigna.com/shbp** or by calling 1-800-633-8519 **or www.welcometouhc.com/shbp** or by calling l-877-246-4189 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your payable in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting below for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No	
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- 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 may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

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	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	None
	Specialist visit	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Other practitioner office visit	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Preventive care/screening/immunization	No cost	Not covered	

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 a test	Diagnostic test (x-ray, blood work)	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Imaging (CT/PET scans, MRIs)	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.dch.georgia.gov/shbp.**	Generic drugs	15% coverage; $20 min/$50 max; not subject to deductible	40% coverage; not subject to deductible	
	Preferred brand drugs	25% coverage; $50 min/$80 max; not subject to deductible	40% coverage; not subject to deductible	
	Non-preferred brand drugs	25% coverage; $80 min/$125 max; not subject to deductible	40% coverage; not subject to deductible	
	Specialty drugs	• Tier I: 15% coverage ($20 min/$50 max) • Tier II: 25% coverage ($50 min/$80 max) • Tier III: 25% coverage ($80 min/$125 max)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Physician/surgeon fees	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need immediate medical attention	Emergency room services	15% coinsurance after satisfying the deductible	15% coinsurance after satisfying the deductible	
	Emergency medical transportation	15% coinsurance after satisfying the deductible	15% coinsurance after satisfying the deductible	
	Urgent care	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Physician/surgeon fee	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

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	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Mental/Behavioral health inpatient services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Substance use disorder outpatient services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Substance use disorder inpatient services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you are pregnant	Prenatal and postnatal care	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Delivery and all inpatient services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need help recovering or have other special health needs	Home health care	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Rehabilitation services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	40 therapy visits per Plan year; combined in and out-of-network
	Habilitation services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	40 therapy visits per Plan year; combined in and out-of-network
	Skilled nursing care	15% coinsurance after satisfying the deductible	No coverage	Up to 120 days per Plan year
	Durable medical equipment	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Hospice service	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

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 your child needs dental or eye care	Eye exam	No cost	Not covered	One eye exam every 24 months
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

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.)		
• Routine dental care	• Cosmetic surgery	• Infertility treatment

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.)	
• Dental Coverage for prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	See the SPD at **www.dch.georgia.gov/shbp** for more information

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.

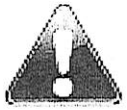
For more information on your rights to continue coverage, contact the plan at 1 800-610-1863. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human 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 your health care vendor directly to appeal denial of coverage for claims. You should contact Cigna at 800-633-8519 or www.mycigna.com/shbp or UnitedHealthcare at 877-246-4189 or www.myuhc.com/shbp. 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.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,336
- **Patient pays** $ 2,204

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,600
Co-pays	$0
Co-insurance	$604
Limits or exclusions	$0
Total	**$2,204**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $2,240
- **Patient pays** $ 1,860

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$1600
Co-pays	$0
Co-insurance	$260
Limits or exclusions	$0
Total	**$1,860**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers,** costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-network and Out-of-network:** • You — Deductible: $ 1,600 — *HRA Credits: $ 500 • You + Child(ren) — $ 2,800 — $1,000 • You + Spouse — $ 2,800 — $1,000 • You + Family — $ 4,000 — $1,500	You must pay all negotiated costs until the deductible is satisfied, after exhausting your HRA Credits, before this plan begins to pay for certain covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. ***HRA Credits will reduce this amount.**
Are there other deductibles for specific services?	No	
Is there an out-of-pocket limit on my expenses?	**In-network and Out-of-network:** • You $ 4,000 • You + Child(ren) $ 6,500 • You + Spouse $ 6,500 • You + Family $ 9,000	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. ***HRA Credits will reduce this amount.**
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, prescription drug coinsurance and any non-covered services this plan doesn't cover	Even though you may pay these expenses, they don't count toward the out-of-pocket limit.
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, such as office visits.

Questions: Call 1-800-610-1863 or visit us at **www.dch.georgia.gov/shbp** for additional information including a copy of your plan's summary plan description. If you aren't clear about any of the underlined terms used in this form, see the SBC Uniform Glossary. You can view the SBC Uniform Glossary at **www.dch.georgia.gov/shbp** or call 1-800-610-1863 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See **www.mycigna.com/shbp** or by calling 1-800-633-8519 **or www.myuhc.com/shbp** or by calling 1-877-246-4189 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some 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?	No	
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- 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 may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

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	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	None
	Specialist visit	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Other practitioner office visit	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Preventive care/screening/immunization	No cost	Not covered	

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 a test	Diagnostic test (x-ray, blood work)	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Imaging (CT/PET scans, MRIs)	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.dch.georgia.gov/shbp.**	Generic drugs	15% coverage; $20 min/$50 max; not subject to deductible	40% coverage; not subject to deductible	
	Preferred brand drugs	25% coverage; $50 min/$80 max; not subject to deductible	40% coverage; not subject to deductible	
	Non-preferred brand drugs	25% coverage; $80 min/$125 max; not subject to deductible	40% coverage; not subject to deductible	
	Specialty drugs	• Tier I: 15% coverage ($20 min/$50 max) • Tier II: 25% coverage ($50 min/$80 max) • Tier III: 25% coverage ($80 min/$125 max)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Physician/surgeon fees	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need immediate medical attention	Emergency room services	15% coinsurance after satisfying the deductible	15% coinsurance after satisfying the deductible	
	Emergency medical transportation	15% coinsurance after satisfying the deductible	15% coinsurance after satisfying the deductible	
	Urgent care	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Physician/surgeon fee	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

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	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Mental/Behavioral health inpatient services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Substance use disorder outpatient services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Substance use disorder inpatient services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you are pregnant	Prenatal and postnatal care	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Delivery and all inpatient services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
If you need help recovering or have other special health needs	Home health care	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Rehabilitation services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	40 therapy visits per Plan year; combined in and out-of-network
	Habilitation services	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	40 therapy visits per Plan year; combined in and out-of-network
	Skilled nursing care	15% coinsurance after satisfying the deductible	No coverage	Up to 120 days per Plan year
	Durable medical equipment	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	
	Hospice service	15% coinsurance after satisfying the deductible	40% coinsurance after satisfying the deductible	

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 your child needs dental or eye care	Eye exam	No cost	Not covered	One eye exam every 24 months
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

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.)		
• Routine dental care	• Cosmetic surgery	• Infertility treatment

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.)	
• Dental Coverage for prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	See the SPD at **www.dch.georgia.gov/shbp** for more information

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.

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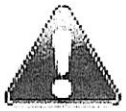
Your Grievance and Appeals Rights:

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 your health care vendor directly to appeal denial of coverage for claims. You should contact Cigna at 800-633-8519 or www.mycigna.com/shbp or UnitedHealthcare at 800-396-6515 or www.myuhc.com/shbp. 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.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,336
- **Patient pays** $ 2,204

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,600
Co-pays	$0
Co-insurance	$604
Limits or exclusions	$0
Total	**$2,204**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $2,440
- **Patient pays** $ 1,860

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$1600
Co-pays	$0
Co-insurance	$260
Limits or exclusions	$0
Total	**$1,860**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers,** costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance.** You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1- 800-610-1863 or visit us at www.dch.georgia.gov/shbp for additional information including a copy of your plan's summary plan description. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.dch.georgia.gov**/shbp or call 1-800-610-1863 to request a copy.

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

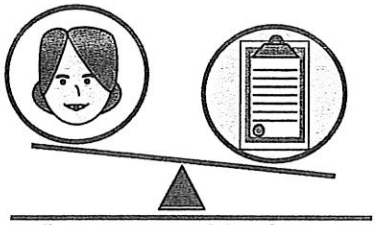
Appeal

A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

Co-insurance



(See page 4 for a detailed example.)

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance ***plus*** any **deductibles** you owe. For example, if the **health insurance** or **plan**'s allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

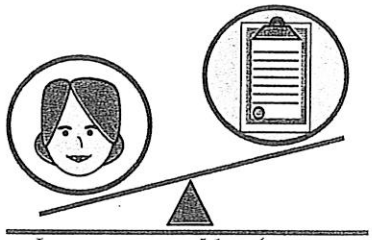
Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible



(See page 4 for a detailed example.)

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or **plan**.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

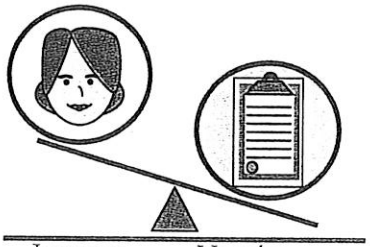
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit


The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.

(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

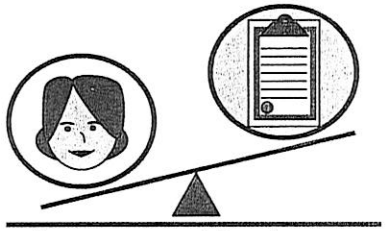
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

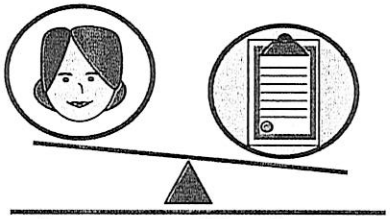
December 31st
End of Coverage Period



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

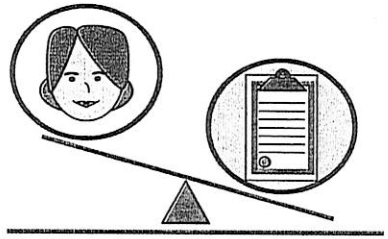
Office visit costs: $125
Jane pays: $125
Her plan pays: $0



Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200