2018

Benefits Enrollment Guide

AMERICAN H·O·M·E MORTGAGE

Your wellness is our focus.

Disclaimer: *This benefit summary highlights key features of the American Home Mortgage benefits program and does not include all plan rules and details. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this summary and the legal plan documents, the plan documents are the final authority. American Home Mortgage reserves the right to change or discontinue its benefit plans at any time without prior advance notice.*

2018 Health Plan Benefit Changes

I am sure you are following the changes to health insurance coverage as a result of health care reform and its impact on the escalating cost of health care and fewer insurance options for coverage. Our plan is not immune to these changes and cost, and as a result, there are changes to our medical, dental and vision benefits effective January 1st.

Blue Cross and Blue Shield will be our new insurer for our medical, dental and vision benefits.

Medical

Blue Cross and Blue Shield of (BCBS) will have two (2) plan options. We have included a Summary of Benefits Coverage (SBC) for each plan option which provides a good overview of the coverages.

The POS Silver Plan has a higher deductible, copays and maximum out of pocket liability. The PPO Gold Plan allows you to elect a richer plan with lower copays, deductible and out of pocket maximum if this is the best option for you and your family. American Home Mortgage will continue to pay the equivalent of the Employee coverage for the Silver Plan regardless of which plan you select.

Preventive care services are covered at 100% for in-network providers. It is important that you obtain all of your care and treatment from in-network providers or your cost share will be significantly higher than outlined in the SBC.

Dental

Dental coverage will also move to Blue Cross and Blue Shield. This is voluntary coverage and the plan will pay for Preventive Benefits up to the reasonable and customary allowance with no deductible. After the deductible, Basic Benefits are payable at 80%, major benefits at 50% - both after the Deductible of $50 per person up to $150 for a family in any one calendar year. The maximum annual payment is $1,000.

Vision

Both the Silver and Gold Plans provide a vision exam, each benefit period, with a $20 copayment. The Materials Only Vision Coverage Plan provides lenses with a $20 copayment. Frames are payable every 24 months and both frames and contacts have a $130 allowance.

This vision policy provides excellent additional coverage for any glasses or contacts that might be needed.

Enrollment

Everyone will need to complete a new enrollment form and return before December 1st for the medical, dental and vision coverages. Options selected during this enrollment period will remain in place until the next annual enrollment period unless you experience a qualified life event.

We know benefits are important to you and your family so we will have an informational webinar on November 21, 2017, at 10:00 am to help answer any questions you may have about the change in insurers and coverage.

Employee Advocate

We also have a specialized Employee Advocate available to help answer any questions or to help you resolve any issues you may have regarding your employee benefits. Please reach out to Ms. Traci Blake at 770.858.4511 or tblake@cbiz.com.

Medical Coverage - BCBS of Georgia		
Type of Plan	**BCBSHP Silver 2X7Y Blue Open Access POS 5400/20%/6850 Focus**	
Overview	You may use both In-Network and Out-of-Network providers Use In-Network providers and receive the In-Network level of benefits. Use Non-Network providers and members are responsible for any difference between the allowed amount and actual charges, as well as any Co-payments and/or applicable coinsurance.	
Annual Deductible	**In-Network**	**Out-of-Network**
Single	$5,400	$16,200
Family	$10,800	$48,600
Annual Out-of-Pocket Maximum	*Includes Deductible and Copays*	
Single	$6,850	$20,550
Family	$13,700	$61,650
Coinsurance	Plan pays 80% after Deductible Member pays 20% after Deductible	Plan pays 50% after Deductible Member pays 50% after Deductible
Deductibles and Co-payment amounts apply to the Out-of-Pocket Maximums. No member of the Family will be responsible for more than the Individual Deductible or Individual Out-of-Pocket Maximum.		
Lifetime Maximum Benefit	Unlimited	
Primary Care Physician Office Visits	$40 Copay	Plan pays 50% after Deductible
Specialist Office Visits	$80 Copay	Plan pays 50% after Deductible
Preventive Care	100% Covered	Plan pays 70% after Deductible
Maternity Physician Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Outpatient Diagnostic Labs and X-Rays	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Hospital Inpatient Expenses *(Facility and Physician Charges)*	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Hospital Outpatient Expenses *(Facility and Physician Charges)*	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Emergency Room and Urgent Care	$300 Copay after Deductible	$300 Copay after Deductible
Urgent Care *(office setting)*	$100 Copay	Plan pays 50% after Deductible
Therapies *(ex: physical, speech and occupational)* *Maximum Annual Benefit*	$80 Copay 20-visit combined maximum	Plan pays 50% after Deductible 20-visit combined maximum
Chiropractic Care *Maximum Annual Benefit*	$80 Coverage after Deductible 20-visit calendar year maximum	Plan pays 50% after Deductible 20-visit calendar year maximum
Skilled Nursing	Plan pays 80% after Deductible Limited to 60 days	Plan pays 50% after Deductible Limited to 50 days
Mental Health, Drug and Alcohol Abuse Treatment Services (*Prior Authorization Required*)	Inpatient: Plan pays 80% after Deductible Outpatient: $40 Copay	Plan pays 70% after Deductible
Prescription Drugs		
Retail Pharmacy (30 day supply)	$5/$15 A / $20/$30B Copays Preferred Generic Drugs $50/$60 Copays for Preferred Brand Drugs $90/$100 Copays for Non-Preferred Drugs 25%/35% up to $500 max for Specialty Drugs	Plan pays 50% after Deductible
Mail Order Maintenance Drug (90 day supply)	$13 A / $50 B Copays for Preferred Generic Drugs $150 Copay for Preferred Brand Drugs $270 Copay for Non-Preferred Drugs 25% after Deductible up to $500 max for Specialty Drugs	Plan pays 50% after Deductible
Semi Monthly Contributions		
Employee Only	$0.00	
Employee + Spouse	$383.53	
Employee + Child(ren)	$326.00	
Employee + Family	$709.52	
Contact Information	Member Services 1.855.397.9267 www.bcbsga.com	

Medical Coverage - BCBS of Georgia		
Type of Plan	**BCBSHP Gold 2X76 Blue Open Access POS 2500/20%/4250**	
Overview	You may use both In-Network and Out-of-Network providers Use In-Network providers and receive the In-Network level of benefits. Use Non-Network providers and members are responsible for any difference between the allowed amount and actual charges, as well as any Co-payments and/or applicable coinsurance.	
Annual Deductible	**In-Network**	**Out-of-Network**
Single	$2,500	$7,500
Family	$7,500	$22,500
Annual Out-of-Pocket Maximum	*Includes Deductible and Copays*	
Single	$4,250	$12,750
Family	$8,500	$38,250
Coinsurance	Plan pays 80% after Deductible Member pays 20% after Deductible	Plan pays 60% after Deductible Member pays 40% after Deductible
Deductibles and Co-payment amounts apply to the Out-of-Pocket Maximums. No member of the Family will be responsible for more than the Individual Deductible or Individual Out-of-Pocket Maximum.		
Lifetime Maximum Benefit	Unlimited	
Primary Care Physician Office Visits	$20 Copay	Plan pays 60% after Deductible
Specialist Office Visits	$40 Copay	Plan pays 60% after Deductible
Preventive Care	100% Covered	Plan pays 70% after Deductible
Maternity Physician Services	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Outpatient Diagnostic Labs and X-Rays	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Hospital Inpatient Expenses *(Facility and Physician Charges)*	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Hospital Outpatient Expenses *(Facility and Physician Charges)*	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Emergency Room and Urgent Care	$250 Copay then Plan pays 80% Coinsurance Copay waived if admitted	$250 Copay then Plan pays 80% Coinsurance Copay waived if admitted
Urgent Care *(office setting)*	$100 Copay	Plan pays 60% after Deductible
Therapies *(ex: physical, speech and occupational)* *Maximum Annual Benefit*	$20 Copay after Deductible 20-visit calendar year maximum	Plan pays 60% after Deductible 20-visit calendar year maximum
Chiropractic Care *Maximum Annual Benefit*	$20 Copay 20-visit calendar year maximum	Plan pays 60% after Deductible 20-visit calendar year maximum
Skilled Nursing (*Prior Authorization Required)*	Plan pays 80% after Deductible Limited to 60 days	Plan pays 60% after Deductible Limited to 60 days
Mental Health, Drug and Alcohol Abuse Treatment Services (*Prior Authorization Required)*	Inpatient: Plan pays 80% Coinsurance Outpatient: $20 Copay	Inpatient: Plan pays 60% after Deductible Outpatient: Plan pays 60% after Deductible
Prescription Drugs		
Retail Pharmacy (30 day supply)	$5/$15 A / $20/$30 B Copays for Preferred Generic Drugs $40/$50 Copays for Preferred Brand Drugs $80/$90 Copays for Non-Preferred Drugs 25%/35% up to $300 max for Specialty Drugs	Plan pays 60% after Deductible
Mail Order Maintenance Drug (90 day supply)	$13 A / $50 B Copays for Preferred Generic Drugs $120 Copay for Preferred Brand Drugs $240 Copay after Deductible for Non-Preferred Drugs 25% up to $300 max for Specialty Drugs	Plan pays 60% after Deductible
Semi Monthly Contributions		
Employee Only	$101.84	
Employee + Spouse	$587.20	
Employee + Child(ren)	$514.39	
Employee + Family	$999.75	
Contact Information	Member Services 1.855.397.9267 www.bcbsga.com	

Dental Coverage - BCBS of Georgia	
Type of Plan	**Benefits**
	In-Network
Deductible	
Single	$50
Family	$150
Annual Maximum Benefit	$1,000
Preventive Services *(oral exam, cleaning, x-rays)*	100% Covered
Basic Services *(fillings, simple extractions)*	80% after Deductible
Major Services *(crowns, bridges, dentures, root canals, periodontics)*	50% after Deductible
Semi Monthly Contributions	
Employee Only	$18.81
Employee + Spouse	$38.37
Employee + Child(ren)	$42.53
Employee + Family	$64.64
Contact Information	Member Services 1.855.397.9267 www.bcbsga.com

Vision (Material Coverage Only) - BCBS of Georgia Blue View Vision Network *(Private Optometrists, LensCrafters, Sears, JC Penny, 1-800-Contacts, ContactsDirect and Glasses.com)*		
	In-Network	**Out-of-Network**
Comprehensive Eye	Once per 12 months	
Examination	$20 Copay - Covered under Medical plan	Reimbursed up to $30
Eyeglass Lenses	Once per 12 months	
Single Vision	$20 Copay	Reimbursed up to $40
Bifocal Vision	$20 Copay	Reimbursed up to $60
Trifocal Vision	$20 Copay	Reimbursed up to $80
Standard Progressive Vision	$65 Copay	Not Covered
Premium Progressive Vision	$85 to $110 Copay	Not Covered
Frames	Once per 24 months	
Standard	$20 Copay $130 Allowance then 20% off any remaining balance	Not Covered
Contact Lenses (in lieu of lenses and frames)	Once per Calendar Year	
Standard Contact Lenses	$130 Allowance then 15% off any remaining balance	Reimbursed up to $92
Premium Contact Lenses	$130 Allowance	Reimbursed up to $92
Semi Monthly Contributions		
Employee Only	$3.42	
Employee + Spouse	$5.98	
Employee + Child(ren)	$5.84	
Employee + Family	$9.41	
Contact Information	Member Services 1.855.397.9267 www.bcbsga.com	

BlueCross BlueShield of Georgia

Your Rx Choice Tiered Network

Many choices and great coverage. Here's how it works.

We've created a network of pharmacies to give you lots of choices and flexibility when you fill prescriptions. The Rx Choice Tiered Network operated by our pharmacy benefits manager, Express Scripts, includes many popular grocery chains, stores and independent drugstores to choose from.

Two levels of coverage

You'll be able to choose from two levels of coverage in the network.

Level 1 includes nearly 25,000 pharmacies where you can get your prescriptions filled for the copay or percentage of the drug costs you normally pay as part of your prescription drug plan. Level 1 includes popular chains such as:

- CVS
- Target
- Walmart
- Kroger
- Safeway

Level 2 offers you more pharmacy choices, but you'll also pay a little more — an extra amount on top of your share of the drug cost, depending on your benefit — no matter which drug you fill. Pharmacies available on Level 2 include:

- Publix
- Walgreens
- Rite Aid
- Giant Eagle

What's the bottom line?

You can save on out-of-pocket costs if you fill your prescription at a Level 1 pharmacy. If you've been using a Level 2 pharmacy, you can keep using it and pay the extra cost, or you can switch to a Level 1 pharmacy and save money.

Whether you choose Level 1 or Level 2, the Rx Choice Tiered Network still gives you many choices to fill your prescriptions. Combined, the two levels include more than 70,000 pharmacies around the country.

Want to know which level your pharmacy is on?

You can find out which level your pharmacy is on by going to bcbsga.com. Choose **Manage Your Prescriptions** on the homepage, and after logging in, select **Locate a Pharmacy** under *Pharmacy Benefits* for a list of pharmacies and the level they're on.

If you aren't registered on the website, you can find pharmacies by city and state or ZIP code in our online tool on bcbsga.com without logging in. Just choose **Find a Doctor** in the homepage menu. You can also view printed pharmacy listings at bcbsga.com/pharmacyinformation/rxnetworks.html.

Questions?

To get the most from your prescription drug plan, call us at the Member Services number on your ID card.

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.bcbsga.com/eocdps/2X76SMG01012018. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 837-8541 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500**/person or **$7,500**/family for In-Network Providers. **$7,500**/person or **$22,500**/family for Non-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care, Primary Care Visit, and Specialist visit for In-Network Providers. Dental, Tier 1a, Tier 1b, Tier 2, Tier 3 and Tier 4 Prescription Drugs, and Vision for In-Network and Non-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,250**/person or **$8,500**/family for In-Network Providers. **$12,750**/person or **$38,250**/family for Non-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, and Non-Network Transplants.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, Blue Open Access POS. See www.bcbsga.com or call (855) 837-8541 for a list of network providers.	You pay the least if you use a provider in Preferred Network. You pay more if you use a provider in In-Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network

		provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable	$20/visit deductible does not apply	40% coinsurance	--------none--------
	Specialist visit	Not Applicable	$40/visit deductible does not apply	40% coinsurance	--------none--------
	Preventive care/screening/ immunization	Not Applicable	No charge	30% coinsurance	Non-Network preventive care services for children prior to their 6th birthday have no deductible. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Not Applicable	20% coinsurance	40% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	Not Applicable	20% coinsurance	40% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyi	Tier 1a - Typically Lower Cost Generic	$5/prescription deductible does not apply (retail) and $13/prescription deductible does not apply (home delivery)	$15/prescription deductible does not apply (retail)	40% coinsurance deductible does not apply (retail and home delivery)	*See Prescription Drug section
	Tier 1b - Typically Generic	$20/prescription deductible does not apply (retail) and $50/prescription	$30/prescription deductible does not apply (retail)	40% coinsurance deductible does not apply (retail and home delivery)	

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.bcbsga.com/eocdps/2X76SMG01012018.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
		deductible does not apply (home delivery)			
nformation/ Anthem Select Drug List	Tier 2 - Typically Preferred Brand & Non-Preferred Generics	$40/prescription deductible does not apply (retail) and $120/prescription deductible does not apply (home delivery)	$50/prescription deductible does not apply (retail)	40% coinsurance deductible does not apply (retail and home delivery)	
	Tier 3 - Typically Non-Preferred Brand	$80/prescription deductible does not apply (retail) and $240/prescription deductible does not apply (home delivery)	$90/prescription deductible does not apply (retail)	40% coinsurance deductible does not apply (retail and home delivery)	
	Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $300 deductible does not apply (retail and home delivery)	35% coinsurance up to $300 deductible does not apply (retail)	40% coinsurance deductible does not apply (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	20% coinsurance	40% coinsurance	--------none--------
	Physician/surgeon fees	Not Applicable	20% coinsurance	40% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	Not Applicable	$250/visit deductible does not apply then 20% coinsurance	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	Not Applicable	20% coinsurance	Covered as In-Network	$50,000 maximum benefit/occurrence for Non-Network Providers.
	Urgent care	Not Applicable	$100/visit deductible does not apply	40% coinsurance	--------none--------
If you have a	Facility fee (e.g., hospital room)	Not Applicable	20% coinsurance	40% coinsurance	60 days/benefit period for

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.bcbsga.com/eocdps/2X76SMG01012018.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
hospital stay					Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	Not Applicable	20% coinsurance	40% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit Not Applicable Other Outpatient Not Applicable	Office Visit $20/visit deductible does not apply Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	Not Applicable	20% coinsurance	40% coinsurance	--------none--------
If you are pregnant	Office visits	Not Applicable	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Not Applicable	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	Not Applicable	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not Applicable	$20/visit deductible does not apply	40% coinsurance	120 visits/benefit period.
	Rehabilitation services	Not Applicable	$20/visit deductible does not apply	40% coinsurance	*See Therapy Services section
	Habilitation services	Not Applicable	$20/visit deductible does not apply	40% coinsurance	
	Skilled nursing care	Not Applicable	20% coinsurance	40% coinsurance	60 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Durable medical equipment	Not Applicable	20% coinsurance	40% coinsurance	*See Durable Medical Equipment Section
	Hospice services	Not Applicable	20% coinsurance	40% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not Applicable	No charge	Amount above $30 reimbursement/visit deductible does not apply	*See Vision Services section
	Children's glasses	Not Applicable	No charge	Amount above $45	

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.bcbsga.com/eocdps/2X76SMG01012018.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
				reimbursement/occurrence deductible does not apply	
	Children's dental check-up	Not Applicable	10% coinsurance deductible does not apply	10% coinsurance deductible does not apply	*See Dental Services section

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Hearing aids 1 unit every 48 months for left ear and 1 unit every 48 months for right ear for children 18 years of age or under. $3,000 maximum/hearing aid.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Routine eye care (Adult) 1 exam/benefit period.
- Spinal Manipulation 20 visits/benefit period.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, WestTower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, www.oci.ga.gov/ConsumerService/Home.aspx. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

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

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.bcbsga.com/eocdps/2X76SMG01012018.

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

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

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.bcbsga.com/eocdps/2X76SMG01012018.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist *copayment*	$40
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,310**

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

The plan's overall deductible	$2,500
Specialist *copayment*	$40
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$107
Copayments	$2,275
Coinsurance	$27
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,464**

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

The plan's overall deductible	$2,500
Specialist *copayment*	$40
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,133
Copayments	$200
Coinsurance	$283
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,616**

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

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 837-8541

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 837-8541 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 837-8541.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 837-8541:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nià kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (855) 837-8541.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 837-8541 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 837-8541 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 837-8541。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (855) 837-8541.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 837-8541.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 837-8541 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 837-8541.

Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 837-8541.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 837-8541.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 837-8541.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 837-8541.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 837-8541 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 837-8541.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 837-8541.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 837-8541.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 837-8541.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 837-8541

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 837-8541 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 837-8541 ។

Language Access Services:

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 837-8541.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 837-8541 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (855) 837-8541.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídíłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h ílínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih ninízingo kojíʼ hodíílnih (855) 837-8541.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 837-8541

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 837-8541 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (855) 837-8541 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 837-8541.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (855) 837-8541.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 837-8541 ਤੇ ਕਾਲ ਕਰੋ।

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (855) 837-8541.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 837-8541.

Language Access Services:

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ʻaia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (855) 837-8541.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (855) 837-8541.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 837-8541.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 837-8541.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (855) 837-8541 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (855) 837-8541.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (855) 837-8541 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 837-8541.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (855) 837-8541.

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (855) 837-8541.

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.bcbsga.com/eocdps/2X7YSMG01012018. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 837-8541 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$5,400**/person or **$10,800**/family for In-Network Providers. **$16,200**/person or **$48,600**/family for Non-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care, Primary Care Visit, and Specialist visit for In-Network Providers. Dental, Tier 1a, Tier 1b and Tier 2 Prescription Drugs, and Vision for In-Network and Non-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$6,850**/person or **$13,700**/family for In-Network Providers. **$20,550**/person or **$61,650**/family for Non-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, and Non-Network Transplants.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, Blue Open Access POS. See www.bcbsga.com or call (855) 837-8541 for a list of network providers.	You pay the least if you use a provider in Preferred Network. You pay more if you use a provider in In-Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network

		provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable	$40/visit deductible does not apply	50% coinsurance	--------none--------
	Specialist visit	Not Applicable	$80/visit deductible does not apply	50% coinsurance	--------none--------
	Preventive care/screening/ immunization	Not Applicable	No charge	30% coinsurance	Non-Network preventive care services for children prior to their 6th birthday have no deductible. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Not Applicable	20% coinsurance	50% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	Not Applicable	20% coinsurance	50% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyi	Tier 1a - Typically Lower Cost Generic	$5/prescription deductible does not apply (retail) and $13/prescription deductible does not apply (home delivery)	$15/prescription deductible does not apply (retail)	50% coinsurance deductible does not apply (retail and home delivery)	*See Prescription Drug section
	Tier 1b - Typically Generic	$20/prescription deductible does not apply (retail) and $50/prescription	$30/prescription deductible does not apply (retail)	50% coinsurance deductible does not apply (retail and home delivery)	

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.bcbsga.com/eocdps/2X7YSMG01012018.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
nformation/ Anthem Select Drug List		deductible does not apply (home delivery)			
	Tier 2 - Typically Preferred Brand & Non-Preferred Generics	$50/prescription deductible does not apply (retail) and $150/prescription deductible does not apply (home delivery)	$60/prescription deductible does not apply (retail)	50% coinsurance deductible does not apply (retail and home delivery)	
	Tier 3 - Typically Non-Preferred Brand	$90/prescription (retail) and $270/prescription (home delivery)	$100/prescription (retail)	50% coinsurance (retail and home delivery)	
	Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $500 (retail and home delivery)	35% coinsurance up to $500 (retail)	50% coinsurance (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	20% coinsurance	50% coinsurance	--------none--------
	Physician/surgeon fees	Not Applicable	20% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	Not Applicable	$300/visit	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	Not Applicable	20% coinsurance	Covered as In-Network	$50,000 maximum benefit/occurrence for Non-Network Providers.
	Urgent care	Not Applicable	$100/visit deductible does not apply	50% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	20% coinsurance	50% coinsurance	60 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	Not Applicable	20% coinsurance	50% coinsurance	--------none--------
If you need mental health, behavioral	Outpatient services	Office Visit Not Applicable Other Outpatient	Office Visit $40/visit deductible does not	Office Visit 50% coinsurance Other Outpatient	Office Visit --------none-------- Other Outpatient

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.bcbsga.com/eocdps/2X7YSMG01012018.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
health, or substance abuse services		Not Applicable	apply Other Outpatient 20% coinsurance	50% coinsurance	--------none--------
	Inpatient services	Not Applicable	20% coinsurance	50% coinsurance	--------none--------
If you are pregnant	Office visits	Not Applicable	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Not Applicable	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	Not Applicable	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not Applicable	$40/visit deductible does not apply	50% coinsurance	120 visits/benefit period.
	Rehabilitation services	Not Applicable	$80/visit deductible does not apply	50% coinsurance	*See Therapy Services section
	Habilitation services	Not Applicable	$80/visit deductible does not apply	50% coinsurance	
	Skilled nursing care	Not Applicable	20% coinsurance	50% coinsurance	60 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Durable medical equipment	Not Applicable	50% coinsurance	50% coinsurance	*See Durable Medical Equipment Section
	Hospice services	Not Applicable	20% coinsurance	50% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not Applicable	No charge	Amount above $30 reimbursement/visit deductible does not apply	*See Vision Services section
	Children's glasses	Not Applicable	No charge	Amount above $45 reimbursement/occurrence deductible does not apply	
	Children's dental check-up	Not Applicable	10% coinsurance	10% coinsurance	*See Dental Services section

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.bcbsga.com/eocdps/2X7YSMG01012018.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
			deductible does not apply	deductible does not apply	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Hearing aids 1 unit every 48 months for left ear and 1 unit every 48 months for right ear for children 18 years of age or under. $3,000 maximum/hearing aid.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Routine eye care (Adult) 1 exam/benefit period.
- Spinal Manipulation 20 visits/benefit period.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, WestTower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, www.oci.ga.gov/ConsumerService/Home.aspx. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

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

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, WestTower, Suite 716, Atlanta,

Georgia 30334, (800) 656-2298, www.oci.ga.gov/ConsumerService/Home.aspx

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

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.bcbsga.com/eocdps/2X7YSMG01012018.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.bcbsga.com/eocdps/2X7YSMG01012018.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5,400
Specialist *copayment*	$80
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,370
Copayments	$0
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,910**

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

The plan's overall deductible	$5,400
Specialist *copayment*	$80
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$107
Copayments	$2,985
Coinsurance	$27
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,174**

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

The plan's overall deductible	$5,400
Specialist *copayment*	$80
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,122
Copayments	$560
Coinsurance	$294
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,976**

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

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 837-8541

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 837-8541 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 837-8541.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 837-8541:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nià kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (855) 837-8541.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 837-8541 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 837-8541 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 837-8541。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (855) 837-8541.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 837-8541.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 837-8541 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 837-8541.

Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 837-8541.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 837-8541.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 837-8541.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 837-8541.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 837-8541 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 837-8541.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 837-8541.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 837-8541.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 837-8541.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 837-8541

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 837-8541 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 837-8541 ។

Language Access Services:

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 837-8541.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 837-8541 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (855) 837-8541.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídíłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h ílínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih ninízingo kojíʼ hodíílnih (855) 837-8541.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 837-8541

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 837-8541 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (855) 837-8541 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 837-8541.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (855) 837-8541.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 837-8541 ਤੇ ਕਾਲ ਕਰੋ।

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (855) 837-8541.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 837-8541.

Language Access Services:

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ʻaia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (855) 837-8541.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (855) 837-8541.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 837-8541.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 837-8541.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (855) 837-8541 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (855) 837-8541.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (855) 837-8541 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 837-8541.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (855) 837-8541.

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (855) 837-8541.

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

2018 Health Plan Notices

⋆ Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema).

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

⋆ The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a new federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The new law prevents discrimination from health insurers and employers. The President signed the act into federal law on May 21, 2008. The parts of the law relating to health insurers will take effect by May 2009, and those relating to employers will take effect by November 2009.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

Important Notice from American Home Mortgage About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Aetna through American Home Mortgage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicate Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Aetna has determined that the prescription drug coverage offered by American Home Mortgage Health Benefits Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lost your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current American Home Mortgage Health Benefits Plan coverage will coordinate with Medicare D.

If you do decide to join a Medicare drug plan and drop your current American Home Mortgage Health Benefits Plan coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with American Home Mortgage Health Benefits Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage . . .

Contact our office for further information or call Aetna at (888) 422-2128. NOTE: You will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through American Home Mortgage Health Benefits Plan changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage . . .

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore whether or not you are required to pay a higher premium (penalty).

Date:	December 16, 2017
Name of Entity/Sender:	American Home Mortgage
Contact--Position/Office:	Gail Sammons
Address:	4840 Roswell Road, E-300, Atlanta, GA 30342
Phone Number:	(404) 478-9240

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility –

<table>
<tr><th>ALABAMA – Medicaid</th><th>COLORADO – Medicaid</th></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447</td><td rowspan="2">Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><th>ALASKA – Medicaid</th></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td><td></td></tr>
<tr><th>ARIZONA – CHIP</th><th>FLORIDA – Medicaid</th></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
</table>

IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2018)

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 Gail Sammons 404 478-9240.

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)
American Home Mortgage	58-1582772
5. Employer address	**6. Employer phone number**
One Premier Plaza, 5605 Glenridge Drive Ste 1050	404-478-9240

7. City	8. State	9. ZIP code
Atlanta	GA	30342

10. Who can we contact about employee health coverage at this job?	
Gail Sammons	
11. Phone number (if different from above)	**12. Email address**
	gsammons@loansite.com

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

- As your employer, we offer a health plan to:

[x] All employees. Eligible employees are:

Full-time employees who work a minimum of 30 hours per week

[ ] Some employees. Eligible employees are:

- With respect to dependents:

[x] We do offer coverage. Eligible dependents are:

*Legal spouses

*Children up to age 26 to include: natural born children, step children, legally adopted children; grandchildren if employee has court ordered power of attorney. Handicapped dependent children are also eligible beyond age 26

[ ] We do not offer coverage.

[x] 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)

Georgia Consumer Choice Option

What is Consumer Choice?

Georgia law requires insurers to offer a "Consumer Choice" option to members enrolling in an insured HMO, POS or PPO plan. This Consumer Choice option allows members to receive services from a non-network provider (physician, hospital or other provider) while still being covered at an in-network level.

Although members may "nominate" any non-network provider, the nominated doctor or hospital must first agree to the following in order for the member's services to be covered at the in-network rate:

1) Accept the insurer's reimbursement as payment in full (in addition to the member's usual copayments, deductibles and/or coinsurance)
2) Comply with the insurer's utilization management programs

Is there a charge to elect the Consumer Choice Option?

Yes. The law allows insurers to increase the monthly premium rate for members who elect this offering. The amount of the monthly premium increase is 17.5% for Consumer Choice Option HMO and POS benefit plans, and 10% for Consumer Choice Option PPO plans.

How do I choose the Consumer Choice Option?

Selecting the Consumer Choice Option is just like selecting any other benefit option. You must do so either at open enrollment, if you are a new hire, or when your employer's eligibility rules allow you to do so. To select the Consumer Choice Option:

1) *Newly applying members* must complete the insurer's Member Enrollment Application and select the Consumer Choice Option plan desired. (Members must still select a network Primary Care Physician for each person enrolled if a HMO or POS Consumer Choice Option is selected.)
2) *Currently enrolled members* must complete a Member Change Form and select the Consumer Choice Option plan desired.

How is the Consumer Choice Option different from a PPO or POS plan?

A PPO or POS plan allows members access to out-of-network providers at an out-of-network benefit level. When a member utilizes the services of an out-of-network provider, the member usually pays more in the form of increased copayments, deductibles and/or coinsurance.

Under the Consumer Choice Option, members may utilize the services of an out-of-network provider at in-network benefit levels only when that provider has:

1) Been nominated by the member:
2) Signed a form accepting the insurer's conditions; and

3) Been approved by the insurer.

After a provider has been approved, the member's benefits are paid as though the provider were part of the insurer's network.

Once I elect the Consumer Choice Option, can I go to any doctor and get benefits paid at in-network levels?

No. First, you must complete a Provider Nomination Form and receive notification from the insurer that the nomination has been accepted before out-of-network providers can be reimbursed at in-network benefit levels.

For any nomination to be approved, the provider must sign the nomination form agreeing to the insurer's terms and conditions before that provider's services will be covered at in-network levels. The provider has absolute discretion regarding whether he or she wishes to participate in the Consumer Choice Option.

How do I nominate my physician?

Call the insurer's customer service department to request a Consumer Choice Physician Nomination Form. Members must complete the provider nomination form, which is a two-step process:

1) The provider must sign the nomination form and request details about the insurer's reimbursement rates for the services he or she intends to provide.
2) The provider must sign the form <u>again</u> to indicate his or her acceptance of the rates and other terms and conditions, once he or she has reviewed them.

After you have completed these steps, please return the completed nomination form to the insurer for approval.

How long will it take to get approval of a nominated provider?

Once the insurer has received a completed nomination form – completed and signed by both the provider and the member – they will respond by mail or fax within three business days.

What if I select the Consumer Choice Option and then decide I want to return to a non-Consumer Choice Option plan?

Under most employers' rules, you may make a plan election only once during each year. If your employer's rules allow you to switch plans other than during your open enrollment period, you may move from the Consumer Choice Option plan you elected back to the non-Consumer Choice version of that plan within 31 days of enrolling. Please check with your employer for details. Your employer must submit any such requests in writing to the insurer.

What if my doctor doesn't want to accept reimbursement terms or comply with utilization management guidelines required by the insurer?

The law does not obligate a provider to accept the terms and conditions or reimbursement rates. If a provider elects not to sign the Consumer Choice Option Provider Nomination Form, he or she is under no obligation to do so.

If you are seeking services from a specific provider, check with that provider BEFORE completing the Consumer Choice Option application and making a final plan election. Once you have selected a Consumer Choice Option plan, you cannot switch plans until the following open enrollment, except within 31-day grace period described above.

Once a doctor has agreed to your terms, can I receive services from that doctor or hospital for the remainder of the time I'm enrolled in the health plan?

Once the provider has signed the form agreeing to the reimbursement and other terms and conditions, you may utilize the services of the provider until your plan's anniversary the following year. You will need to repeat the nomination/approval process each year for the out-of-network provider's services to be covered at in-network benefit levels.

Will prescriptions written by a non-network doctor be covered?

If you nominate a provider and that provider is ultimately approved under the Consumer Choice Option, he or she may write prescriptions that will be covered at in-network benefit levels. Remember, if your plan restricts you to having prescriptions filled at network pharmacies, you must either use only network pharmacies or have a completed and approved Provider Nomination Form for any non-network pharmacy. (Note: This requirement does not apply to PPO plans.)

If my doctor admits me to a non-network hospital, will the hospital charges be covered?

Any services must be provided by either a network hospital or a hospital for which a Provider Nomination Form has been completed and approved. This form must also be completed and approved for any other providers rendering services – for example, radiology, anesthesia services, physical therapy or lab work. To be eligible for in-network benefit levels, all services must be provided by either in-network providers or providers approved under the Consumer Choice Option.

For additional information about the Consumer Choice Option, please call the insurer's Customer Service Department.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of Coverage)

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Complete If You Are Declining Coverage For Yourself Or Any Dependent:

If you are declining coverage for yourself or for any of your eligible dependents, you must complete the following information if you want to preserve your rights of Special Enrollment as explained above. If you decline coverage for yourself, the reason is:

☐ **I have other coverage** ☐ **Another reason**

If you decline coverage for one or more eligible dependents, please give the dependent's name below and indicate the reason coverage is declined.

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

_____ _____

Employee Name – Please Print Employee Social Security Number

_____ _____/_____/_____

Employee Signature **Date**

Notes

Notes

4840 Roswell Road
Suite E-300
Atlanta, Georgia 30342
404-256-1024

Disclaimer: *This benefit summary highlights key features of the American Home Mortgage benefits program and does not include all plan rules and details. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this summary and the legal plan documents, the plan documents are the final authority. American Home Mortgage reserves the right to change or discontinue its benefit plans at any time without prior advance notice.*