

understand your medical plan options

Georgia SHBP Options	CIGNA Choice Fund® HRA	Open Access Plus	Open Access Plus High Deductible Health Plan HDHP	Open Access Plus In-Network
Preventive Care Physical Exams In-Network Coverage Only	Covered in Full – No charge, no deductible	Covered in Full after \$35 copay/ office visit; no deductible; subject to \$1,000 max/cal. year	Covered in Full – No charge, no deductible	Covered in Full after \$35 copay/ office visit; no deductible
Well Child Exams In-Network Coverage Only	Covered in Full – No charge, no deductible	Covered in Full after \$35 copay/ office visit; no deductible; subject to \$1,000 max/cal. year	Covered in Full – No charge, no deductible	Covered in Full after \$35 copay/ office visit; no deductible
Covered Immunizations In-Network Coverage Only	Covered in Full – No charge, no deductible	Covered in Full – No charge, no deductible	Covered in Full – No charge, no deductible	Covered in Full – No charge, no deductible
Deductible: In-Network	Combined medical/pharmacy		Combined medical/pharmacy	
Individual	\$1,100	\$600	\$1,200	\$600
Employee plus Spouse	\$1,900	\$1,200	\$2,400	\$900
Employee plus Child(ren)	\$1,900	\$1,200	\$2,400	\$900
Family	\$2,750	\$1,800	\$2,400	\$1,200
Deductible: Out-of-Network				
Individual	\$1,100	\$1,200	\$2,400	In-Network Coverage Only
Employee plus Spouse	\$1,900	\$2,400	\$4,800	In-Network Coverage Only
Employee plus Child(ren)	\$1,900	\$2,400	\$4,800	In-Network Coverage Only
Family	\$2,750	\$3,600	\$4,800	In-Network Coverage Only
Coinsurance: In-Network	15%	20%	10%	20%
Coinsurance: Out-of-Network	40%	40%	40%	In-Network Coverage Only
HRA Credit Dollars		N/A	N/A	N/A
Individual	\$500			
Employee plus Spouse	\$1,000			
Employee plus Child(ren)	\$1,000			
Family	\$1,500			
Out-of-Pocket Maximum: In-Network	Combined medical/pharmacy		Combined medical/pharmacy	
Individual	\$2,500	\$2,000 + copays	\$1,800	\$2,000 + copays
Employee plus Spouse	\$4,100	\$3,000 + copays	\$3,100	\$3,000 + copays
Employee plus Child(ren)	\$4,100	\$3,000 + copays	\$3,100	\$3,000 + copays
Family	\$5,700	\$4,000 + copays	\$3,100	\$4,000 + copays
Out-of-Pocket Maximum:				
Out-of-Network	Combined medical/pharmacy		Combined medical/pharmacy	
Individual	\$2,500	\$4,000 + copays	\$4,000	In-Network Coverage Only
Employee plus Spouse	\$4,100	\$6,000 + copays	\$7,400	
Employee plus Child(ren)	\$4,100	\$6,000 + copays	\$7,400	
Family	\$5,700	\$8,000 + copays	\$7,400	
Physician Services: In-Network				
Primary Care Visit	15% after deductible	\$35 copay per office visit	10% after deductible	\$35 copay per office visit
Specialist Visit	15% after deductible		10% after deductible	
Physician Services: Out-of-Network				
Primary Care Visit	40% after deductible	40% after deductible	40% after deductible	In-Network Coverage Only
Specialist Visit	40% after deductible	40% after deductible	40% after deductible	
Inpatient Hospital: In-Network	15% after deductible	\$250 copay per admission, then 20% after deductible	10% after deductible	20% after deductible
Inpatient Hospital: Out-of-Network	40% after deductible	\$250 deductible per admission, then 40% after deductible	40% after deductible	In-Network Coverage Only
Outpatient Hospital: In-Network	15% after deductible	20% after deductible	10% after deductible	20% after deductible
Outpatient Hospital: Out-of-Network	40% after deductible	40% after deductible	40% after deductible	In-Network Coverage Only
Mental Health & Substance Abuse Inpatient: In-Network	15% after deductible	\$250 copay per admission, then 20% after deductible	10% after deductible	20% after deductible

We're available **whenever you need us, 24/7**

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Mental Health & Substance Abuse Inpatient: Out-of-Network	15% after deductible	\$250 deductible per admission, then 40% after deductible	40% after deductible	In-Network Coverage Only
Mental Health & Substance Abuse Outpatient: In-Network	15% after deductible	\$35 copay per office visit	15% after deductible	\$35 copay per office visit
Mental Health & Substance Abuse Outpatient: Out-of-Network	40% after deductible	40% after deductible	40% after deductible	In-Network Coverage Only
Prescription Drug Retail 30 day supply: In-Network	15% after deductible for generic drugs 25% after deductible for preferred brand-name drugs 25% after deductible for non-preferred brand-name drugs	\$15 copay for generic drugs \$40 copay for preferred brand-name drugs \$100 copay for non-preferred brand-name drugs	20% after deductible for generic drugs; \$10 min, \$100 max 20% after deductible for preferred brand-name drugs; \$10 min, \$100 max 20% after deductible for non-preferred brand-name drugs; \$10 min, \$100 max	\$15 copay for generic drugs \$40 copay for preferred brand-name drugs \$75 copay for non-preferred brand-name drugs
Prescription Drug Retail 90 day supply: In-Network Coverage Only	15% after deductible for generic drugs 25% after deductible for preferred brand-name drugs 25% after deductible for non-preferred brand-name drugs	\$45 copay for generic drugs \$120 copay for preferred brand-name drugs \$300 copay for non-preferred brand-name drugs	20% after deductible for generic drugs; \$30 min, \$300 max 20% after deductible for preferred brand-name drugs; \$30 min, \$300 max 20% after deductible for non-preferred brand-name drugs; \$30 min, \$300 max	\$45 copay for generic drugs \$120 copay for preferred brand-name drugs \$225 copay for non-preferred brand-name drugs
Durable Medical Equipment: In-Network	15% of eligible expenses; Subject to deductible	20% of eligible expenses; Subject to deductible	10% of eligible expenses; Subject to deductible	Covered in full – eligible expenses
Durable Medical Equipment: Out-of-Network	40% of eligible expenses; Subject to deductible	40% of eligible expenses; Subject to deductible	40% of eligible expenses; Subject to deductible	N/A
Emergency Health Services: In-Network	15% of eligible expenses; Subject to deductible	20% of eligible expenses; after \$150 copay; Subject to deductible Copay waived if admitted	10% of eligible expenses; Subject to deductible	\$150 copay, waived if admitted
Emergency Health Services: Out-of-Network	15% of eligible expenses; Subject to deductible	20% of eligible expenses; after \$150 copay; Subject to deductible Copay waived if admitted	10% of eligible expenses; Subject to deductible	\$150 copay, waived if admitted
Vision: In-Network	1 eye exam every 24 months; Covered in full; no deductible	1 eye exam every 24 months; 20% of expenses; no deductible	1 eye exam every 24 months; 10% of expenses; no deductible	1 eye exam every 24 months subject to \$35 copay; \$200 hardware allowance per year (may use vision provider of choice - no network requirement on hardware only)
Maternity Services: In-Network	15% of eligible expenses; Subject to deductible	Initial visit \$35 copay; not subject to deductible; then 20% of eligible expenses	10% of eligible expenses; Subject to deductible	Covered in full – after initial \$35 copay
Maternity Services: Out-of-Network	40% of eligible expenses; Subject to deductible	40% of eligible expenses; Subject to deductible	40% of eligible expenses; Subject to deductible	N/A
Urgent Care	15% of eligible expenses; Subject to deductible	20% of eligible expenses; after \$45 copay	10% of eligible expenses; Subject to deductible	\$35 copay

The information in this brochure is provided as a guide only. Make sure to read all your enrollment information thoroughly as plan details may vary. If you need more assistance, talk to your Human Resources representative.



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