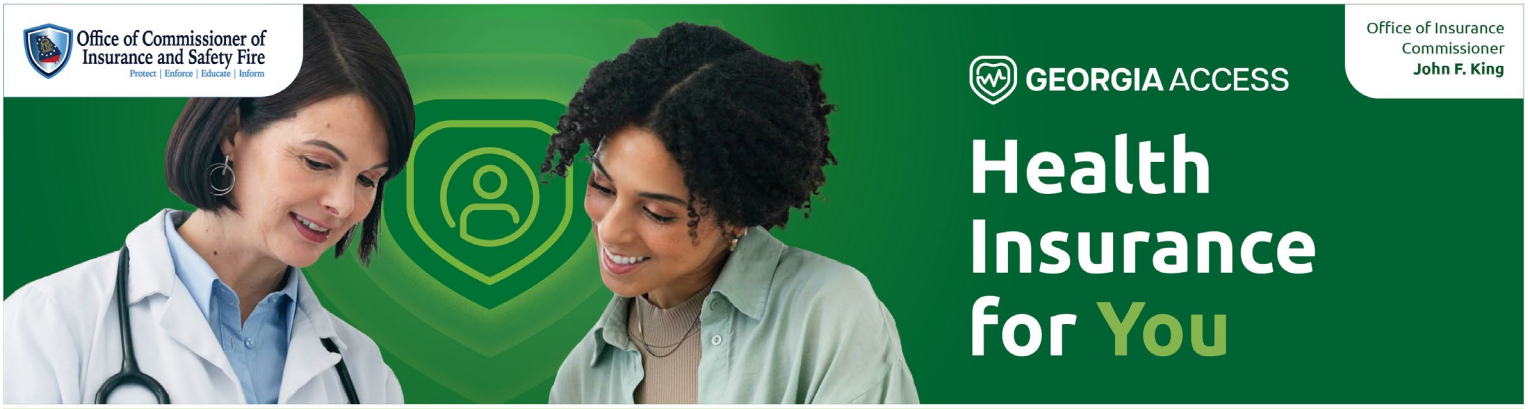

Health Plan Information

This information sheet contains useful information to help you understand health plans sold on Georgia Access.

OVERVIEW

- You can shop for and enroll in a variety of medical plans, known as **Qualified Health Plans** (QHPs), from multiple insurance companies on Georgia Access.
- All plans are certified by Georgia Access and meet federal and state requirements, including coverage of the Essential Health Benefits (EHBs).
- Each plan has a **Summary of Benefits of Coverage** (SBC) sheet which details the specific benefits and costs. Review the SBC to select the plan that best meets your needs. If you need help understanding what a plan covers reach out to an agent or to the insurance company.

Need Dental Coverage?

You can also buy dental coverage through Georgia Access. Some health plans have it embedded as part of the benefits or you can buy just a dental plan, known as a Stand-Alone Dental Plan (SADP).

ESSENTIAL HEALTH BENEFITS (EHBs)

All health plans available through Georgia Access are required to cover the following EHBs. Since all Georgia Access plans provide the same comprehensive basic benefits, it's easier to compare options and select the plan that best fits your needs.

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Pregnancy, maternity, and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventative and wellness services and chronic disease management
10. Pediatric services, including dental and vision care

Did You Know?

All health plans must include coverage for certain preventive services, like annual exams, vaccinations, and screenings. These are usually free when you see an in-network provider. You can review the list of required prevention services on healthcare.gov.

COST-SHARING

- When exploring your health coverage options, you can select different metal-levels. The metal-level identifies how much you pay for covered health care services versus the insurance company (this is known as cost sharing). There are four metal levels: **Bronze**, **Silver**, **Gold**, and **Platinum**.
- **Catastrophic health plans** are high-deductible plans with low monthly premiums, high deductibles, and high out-of-pocket costs. These plans are available if you're under 30 or if you qualify for an exemption.
- It's important to understand costs and benefits before enrolling as out-of-pocket costs vary by plan, and some plans do not have deductibles. The table below provides estimated cost sharing levels by plan type.

Plan Type	On Average You Pay __ Total Cost of Care	On Average, the Plan Pays __ Total Cost of Care	Typical Monthly Premium	Typical Deductible
Platinum	**10%**	90%	High	Low
Gold	**20%**	80%	High	Low
Silver*	**30%**	70%	Moderate	Moderate
Bronze	**40%**	60%	Low	High
Catastrophic	**Varies**	Varies	Low	High

**You may be eligible for extra savings which lower your out-of-pocket costs if you are eligible and enroll in a Silver Plan. These are known as Cost-Sharing Reductions (CSRs).*

HELPFUL TERMINOLOGY

- Health insurance can be complicated, but understanding some key terms can make it easier to compare costs and choose the right plan that meets your medical needs and budget.
- Copayments, deductibles, coinsurance, premiums, and the maximum out-of-pocket limits determine how much you as the consumer are responsible for paying when receiving medical care for covered services. Deductibles, copayments, and coinsurance levels vary by plan. Costs also depend on whether you see in-network or out-of-network providers.

Term	Description	Example
Coinsurance	Coinsurance is a set percentage you must pay when receiving medical care, typically after you have met your deductible. Your plan typically bills you for your portion of the costs after receiving care. **Note:** The coinsurance percentage varies based on the covered service and whether you receive care from a provider that is in or out of the plan's network.	*You go to urgent care and the total cost for the visit is $100. Your plan has a 30% coinsurance for urgent care visits. You will be required to pay $30 and your insurance company will pay $70.*
Copayment	A copayment (or "copay") is a set fee you must pay when receiving medical care, typically after your deductible has been met. Copays are usually paid at the time of your doctor's visit or when filling a prescription. **Note:** Copay amounts vary based on the covered service, such as a doctor's visit, prescription medication, lab tests, or specialist visit. They also vary depending on whether you receive care from an in-network or out-of-network provider.	*You go to urgent care and the total cost for the visit is $100. Your plan has a $25 copay for urgent care visits. You will be required to pay $25 and your insurance company will pay $75.*
Deductible	A deductible is the set amount of money you must first pay for medical care in a year before your insurance starts to pay. Once your deductible is fully paid (or "met"), your insurance company pays part of the cost for covered services for the rest of the year. **Note:** Some services such as preventive care (e.g., annual exams), are exempt from deductibles. This means the insurance company pays for the service even if your deductible has not yet been met. Some plans do not have a deductible.	*Your plan's deductible is $2,000. You have not yet received medical care this year and need to go to an urgent care. The total cost of the visit is $100. You will be required to pay the full $100.*
In-Network	In-network refers to the doctors, hospitals, and pharmacies that an insurance company contracts with to provide health care services for members enrolled in their plans. These are commonly referred to as a "network providers" or "preferred providers." Providers who do not contract with your plan are considered "out-of-network" and cost more.	*You need to go to an urgent care. You review the list of urgent care providers in your plan's network to identify one close to you.*
Maximum Out-Of-Pocket	The maximum out-of-pocket (or "MOOP") is the most you might have to pay for covered medical care in a year. Once you reach this limit, your insurance company covers 100% of covered services received from in-network providers for the rest of the year. **Note:** The MOOP does not include your monthly premiums and can vary for each plan. For Plan Year 2026, the MOOP cannot exceed $10,600 for an individual or $21,200 for a family. Consumers who meet eligibility criteria for Cost-Sharing-Reductions, may enroll in a Silver plan with a reduced MOOP.	*You go to an urgent care, and the total cost for the visit is $100. You've already paid $10,600 in out-of-pocket medical cost for the year, so your insurance company pays the full $100 urgent care bill.*
Premium	A premium is the amount you pay the insurance company each month to maintain your health insurance coverage. **Note:** You must pay monthly to keep your coverage even if you don't receive medical care during a month.	*The full cost of your plan is $500/month. You are eligible for federal subsidies which lowers your costs, so your monthly premium amount is $25. You pay this to the insurance company every month.*

Contact Us

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Hours: Mon – Fri: 8 AM – 5 PM ET *(Excluding Holidays)*
Website: https://georgiaaccess.gov