



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, visit [www.shbp.georgia.gov](http://www.shbp.georgia.gov) or call 1-888-364-6352. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-888-364-6352 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> : <b>\$1,300</b> You <b>\$1,950</b> You + Spouse or Child(ren) <b>\$2,600</b> You + Family. For <a href="#">out-of-network providers</a> : Not Covered	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> <b>\$4,000</b> You <b>\$6,500</b> You + Spouse or Child(ren)/ <b>\$9,000</b> You + Family; for <a href="#">out-of-network providers</a> : not covered.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.welcometouhc.com/shbp">www.welcometouhc.com/shbp</a> or call 1-888-364-6352 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

\* For more information about limitations and exceptions, see the plan or policy document at <https://shbp.georgia.gov>.



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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$35 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply	Not Covered	There are childhood obesity visit limits.
	<a href="#">Specialist</a> visit	\$45 <a href="#">copay</a> /visit	Not Covered	There are childhood obesity visit limits.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> After Deductible (Outpatient) No Charge (Office)	Not Covered	No charge for Independent Lab for diagnostic tests.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> After Deductible (Outpatient) No Charge (Office)	Not Covered	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://info.caremark.com/shbp">http://info.caremark.com/shbp</a>	Generic drugs and select preferred brand drugs (Tier 1)	\$20 <a href="#">copay</a> /prescription (retail & mail order)	Same <a href="#">copay</a> as <a href="#">network provider</a> , but based on the allowed amount. You must pay out-of-pocket and submit a paper claim for reimbursement. The plan will reimburse you based on the allowed amount for a <a href="#">network provider</a> .	For non-maintenance medication, there is a 31-day supply limit at retail pharmacies. Maintenance medications can be filled for up to a 90-day-supply (retail/home delivery)  For 32 – 62 day supply – monthly <a href="#">copay</a> is doubled  63 – 90 day supply from a non-90-day network pharmacy – monthly <a href="#">copay</a> is tripled  90-day supply at 90-day supply retail pharmacy or through home delivery, monthly <a href="#">copay</a> is multiplied by 2.5  See the Plan Documents for a list of drugs that require <a href="#">Preauthorization</a> or have other limits.
	Preferred brand drugs (Tier 2)	\$50 <a href="#">copay</a> /prescription (retail & mail order)		
	Non-preferred brand drugs (Tier 3)	\$90 <a href="#">copay</a> /prescription (retail & mail order)		
	<a href="#">Specialty drugs</a> (Tier 4)	Same Tier 1, Tier 2, and Tier 3 drugs, as applicable		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> After Deductible	Not Covered	---None---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <a href="#">coinsurance</a> After Deductible	Not Covered	---None---
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit	\$150 <a href="#">copay</a> /visit	<a href="#">Preauthorization</a> required within 1 business day, or as soon as possible, if you are admitted to a non- <a href="#">network</a> Hospital. If admitted, <a href="#">copay</a> is waived.
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	---None---
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a> /visit	Not Covered	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> After Deductible	Not Covered	<a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> After Deductible	Not Covered	---None---
If you need mental health, behavioral health, or substance use services	Outpatient services	\$35 <a href="#">copay</a> /visit (PCP) \$45 <a href="#">copay</a> /visit (SPC) \$10 <a href="#">copay</a> /group visit	Not Covered	---None---
	Inpatient services	20% <a href="#">coinsurance</a> After Deductible	Not Covered	<a href="#">Preauthorization</a> is required.
If you are pregnant	Office visits	No Charge After Initial Visit \$35 <a href="#">copay</a> /visit (PCP) \$45 <a href="#">copay</a> /visit (SPC)	Not Covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> After Deductible	Not Covered	<a href="#">Preauthorization</a> may be required.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> After Deductible	Not Covered	Applies to inpatient facility. Other cost shares may apply depending on the services provided. <a href="#">Preauthorization</a> may be required.
If you need help recovering or have	<a href="#">Home health care</a>	No Charge	Not Covered	One visit equals four hours of skilled care services. <a href="#">Preauthorization</a> is required for home health care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copay</a> /visit	Not Covered	There is a benefit maximum of 40 visits per therapy in a benefit year (physical, occupational, speech, cardiac rehab, pulmonary rehab). Physical Therapy- <a href="#">Preauthorization</a> is required for children only after 40 visits. Services provided by a Home Health agency are NOT subject to 40 visit limitations when performed in a home setting. If performed in a home setting, the home health care benefit applies.
	<a href="#">Habilitation services</a>	\$25 <a href="#">copay</a> /visit	Not Covered	Habilitation visits count toward the rehabilitation visit maximum above.
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	Skilled Nursing Facility 120 days per calendar year. No day limitations for Inpatient Rehab Facility.
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	<a href="#">Preauthorization</a> is required for devices (purchase or cumulative rental) which cost more than \$1,000 per device.
	<a href="#">Hospice services</a>	No Charge	Not Covered	8 bereavement visits per calendar year.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Coverage limited to one routine exam every 24 months.
	Children's glasses	Not Covered	Not covered	Not Covered
	Children's dental check-up	Not Covered	Not covered	Not Covered

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility Treatment</li> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private Duty Nursing</li> <li>Routine Foot Care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> </ul>	

**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: Your state insurance department, Georgia Department of Insurance at 1-800-656-2298 or [www.oci.ga.gov/](http://www.oci.ga.gov/); or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://www.HealthCare.gov) or call 1-800-318-2596. For more information on your rights to continue coverage contact, the plan at 1-800-610-1863.

**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](#). You should contact UnitedHealthcare directly to appeal denial of coverage for medical claims by calling 1-888-364-6352. For appeals related to well-being incentive credits, contact Sharecare at 1-888-616-6411. For questions about your eligibility, rights, this notice, or assistance, you can contact: the State Health Benefit Plan Member Services at 1-800-610-1863 or access information about eligibility appeals at [www.shbp.georgia.gov](http://www.shbp.georgia.gov). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#).

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

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

**Does this plan meet 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](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-364-6352.

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

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](#) \$1300
- [Specialist copayment](#) \$45
- 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*)

<b>Total Example Cost</b>	<b>\$7,540</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1300
Copayments	\$45
Coinsurance	\$1248
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,593</b>

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

- The [plan's](#) overall [deductible](#) \$1300
- [Specialist copayment](#) \$45
- 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*)

<b>Total Example Cost</b>	<b>\$5,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$90
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$90</b>

\*Prescriptions are paid under the pharmacy benefit through CVS caremark.

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

- The [plan's](#) overall [deductible](#) \$1300
- [Specialist copayment](#) \$45
- 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$270
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$270</b>