



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="#">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="#">Search for a provider   State of GA benefits by UnitedHealthcare</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> /visit	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)	\$5 <a href="#">copay</a> /prescription (31-day supply at 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/mail order).  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 mail order, monthly <a href="#">copay</a> is multiplied by 2.5.  Pharmacy copay does not apply to the deductible; however it does apply to the out-of-pocket maximum.  See the Plan Documents for a list of drugs that require <a href="#">Preauthorization</a> or have other limits.
	Preferred brand drugs (Tier 2)	\$55 <a href="#">copay</a> /prescription (31-day supply at retail & mail order)		
	Non-preferred brand drugs (Tier 3)	\$95 <a href="#">copay</a> /prescription (31-day supply at retail & mail order)		
	<a href="#">Specialty drugs</a>	Same Tier 1, Tier 2, and Tier 3 drugs, as applicable		

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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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance After Deductible	Not Covered	---None---
	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>	\$200 <a href="#">copay</a> /visit	\$200 <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	No Charge	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.

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

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 need help recovering or have other special health needs</b>	<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.
	<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). Limits do not apply to Mental Health Conditions. Physical Occupational and Speech Therapy- <a href="#">Preauthorization</a> is required for children only after 40 visits. Limits do not apply to Mental Health conditions. Services provided by a Home Health agency are NOT subject to 40 visit imitations 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.
<b>If your child needs dental or eye care</b>	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

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

## 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
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Chiropractic care
- Routine eye care (Adult)
- Bariatric Surgery
- Hearing Aids

**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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1300
■ <a href="#">Specialist copayment</a>	\$45
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
Deductibles	\$1300
Copayments	\$45
Coinsurance	\$1248
What isn't covered	
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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1300
■ <a href="#">Specialist copayment</a>	\$45
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
Deductibles	\$0
Copayments	\$90
Coinsurance	\$0
What isn't covered	
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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1300
■ <a href="#">Specialist copayment</a>	\$45
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
Deductibles	\$0
Copayments	\$320
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$320</b>