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 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 deductible?	For network providers: **$1,300** You **$1,950** You + Spouse or Child(ren) **$2,600** You + Family. For out-of-network providers: Not Covered	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 services are covered before you meet your deductible.	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?	For network providers **$4,000** You/ **$6,500** You + Spouse or Child(ren)/**$9,000** You + Family; for out-of-network providers: not covered.	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?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	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. See www.welcometouhc.com/shbp or call 1-888-364-6352 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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.

* 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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/office visit; deductible does not apply	Not Covered	There are childhood obesity visit limits.
	Specialist visit	$45 copay/visit	Not Covered	There are childhood obesity limits.
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance After Deductible (Outpatient) No Charge (Office)	Not Covered	No charge for Independent Lab for diagnostic tests.
	Imaging (CT/PET scans, MRIs)	20% coinsurance After Deductible (Outpatient) No Charge (Office)	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://info.caremark.com /shbp	Generic drugs (Tier 1)	$20 copay/prescription (retail & mail order)	Same copay as network provider, 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 network provider.	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 copay is doubled 63 – 90 day supply from a non-90-day network pharmacy – monthly copay is tripled 90-day supply at 90-day supply retail pharmacy or through home delivery, monthly copay is multiplied by 2.5 See the Plan Documents for a list of drugs that require Preauthorization or have other limits.
	Preferred brand drugs (Tier 2)	$50 copay/prescription (retail & mail order)		
	Non-preferred brand drugs (Tier 3)	$90 copay/prescription (retail & mail order)		
	Specialty drugs (Tier 4)	Same as Generic, Preferred, Non-preferred brand drugs, as applicable		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance 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% coinsurance After Deductible	Not Covered	---None---
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Preauthorization required within 1 business day, or as soon as possible, if you are admitted to a non-network Hospital. If admitted, copay is waived.
	Emergency medical transportation	No Charge	No Charge	---None---
	Urgent care	$35 copay/visit	Not Covered	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance After Deductible	Not Covered	Preauthorization may be required.
	Physician/surgeon fees	0% coinsurance After Deductible	Not Covered	---None---
If you need mental health, behavioral health, or substance use services	Outpatient services	$35 copay/visit (PCP) $45 copay/visit (SPC) $10 copay/group visit	Not Covered	---None---
	Inpatient services	20% coinsurance After Deductible	Not Covered	Preauthorization is required.
If you are pregnant	Office visits	No Charge After Initial Visit $35 copay/visit (PCP) $45 copay/visit (SPC)	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance After Deductible	Not Covered	Preauthorization may be required.
	Childbirth/delivery facility services	20% coinsurance After Deductible	Not Covered	Applies to inpatient facility. Other cost shares may apply depending on the services provided. Preauthorization may be required.
If you need help recovering or have	Home health care	No Charge	Not Covered	One visit equals four hours of skilled care services. Preauthorization 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	Rehabilitation services	$25 copay/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-Preauthorization 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.
	Habilitation services	$25 copay/visit	Not Covered	Habilitation visits count toward the rehabilitation visit maximum above.
	Skilled nursing care	No Charge	Not Covered	Skilled Nursing Facility 120 days per calendar year. No day limitations for Inpatient Rehab Facility.
	Durable medical equipment	No Charge	Not Covered	Preauthorization is required for devices (purchase or cumulative rental) which cost more than $1,000 per device.
	Hospice services	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 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
- 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
- Hearing Aids
- Routine eye care (Adult)

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/; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan.

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 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)*

Total Example Cost	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1300
Copayments	$45
Coinsurance	$1248
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,593**

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)*

Total Example Cost	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$90**

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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$270**

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