



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://dch.georgia.gov/shbp-plan-documents> or by calling 1-888-364-6352.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	<u>In-Network:</u> \$3,500 You \$7,000 You + Spouse or Child(ren) \$7,000 You + Family <u>Out-of-Network:</u> \$7,000 You \$14,000 You + Spouse or Child(ren) \$14,000 You + Family	You must pay all the costs up to the “ You ” <u>deductible</u> amount before this plan begins to pay for services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the “ You ” <u>deductible</u> .
Are there other deductibles for specific services?	No.	You do not have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <u>In-Network:</u> \$6,450 You \$12,900 You + Spouse or Child(ren) \$12,900 You + Family <u>Out-of-Network:</u> \$12,900 You \$25,800 You + Spouse or Child(ren) \$25,800 You + Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premium, balanced-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .
Does this plan use a <u>network</u> of providers?	Yes. For a list of <u>In-Network Providers</u> , see www.welcometouhc.com/shbp or call 1-888-364-6352.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan does not cover are listed on Page 5. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you have not met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	30% Coinsurance After Deductible	50% Coinsurance After Deductible	There are childhood obesity visit limits.
	Specialist visit	30% Coinsurance After Deductible	50% Coinsurance After Deductible	There are childhood obesity visit limits.
	Other practitioner office visit	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Cost Share applies for only Manipulative (Chiropractic) Care. Spinal Treatment is limited to 20 visits per calendar year. Prior Authorization is also required for benefits provided for Applied Behavioral Analysis (\$35,000 annual limit; covered through age 10). Registered Dietitians- there are visit limits.
	Preventive care/screening/immunization	No Charge	Not Covered	Covered services must be properly coded as preventive and provided by an in-network provider.
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required for Sleep Studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required or benefit reduces to 50% of allowed.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Express-Scripts.com/georgiashbp	Generic drugs	30% coinsurance after deductible is met.	Same coinsurance for In-Network, but based on the allowed amount.	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 or home delivery). See the Plan Documents for a list of drugs that require prior authorization or have other limits.
	Preferred brand drugs	30% coinsurance after deductible is met.	You must pay out-of-pocket and submit a paper claim for reimbursement. The plan will reimburse you based on the allowed amount for In-Network pharmacies.	
	Non-preferred brand drugs	30% coinsurance after deductible is met.		
	Specialty Drugs	30% coinsurance after deductible is met.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization may be required.
	Physician/surgeon fees	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Some providers are not covered as an assistant at surgery. Prior Authorization may be required.
If you need immediate medical attention	Emergency room services	30% Coinsurance After Deductible	30% Coinsurance After Deductible	Prior Authorization required within 1 business day, or as soon as possible, if you are admitted to a non-network Hospital.
	Emergency medical transportation	30% Coinsurance After Deductible	30% Coinsurance After Deductible	---None---
	Urgent care	30% Coinsurance After Deductible	50% Coinsurance After Deductible	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required.
	Physician/surgeon fee	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Some providers are not covered as an assistant at surgery. Prior Authorization may be required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required or benefit reduces to 50% of allowed. Neuropsychological testing does not require Prior Authorization.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs (continued)	Mental/Behavioral health inpatient services	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required or benefit reduces to 50% of allowed. Neuropsychological testing does NOT require a Prior Authorization. Professional Charges Inpatient limited to 1 visit per authorized day combined/calendar year.
	Substance use disorder outpatient services	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required or benefit reduces to 50% of allowed. Professional Charges Inpatient limited to 1 visit per authorized day combined/calendar year.
If you are pregnant	Prenatal and postnatal care	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Your cost in this category includes physician delivery charges. Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Your cost for inpatient services only. For physician delivery charges, see pre-postnatal care. Prior Authorization may be required.
If you need help recovering or have other special health needs	Home health care	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required for Home healthcare.
	Rehabilitation services	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required or benefit reduces to 50% of allowed. There is a benefit maximum of 40 visits per therapy in a benefit year (physical, occupational, speech, cardiac rehab, pulmonary rehab). Physical Therapy-Prior Authorization 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.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs (continued)	Habilitation services	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Habilitation visits count toward the rehabilitation visit maximum above.
	Skilled nursing care	30% Coinsurance After Deductible	Not Covered	Skilled Nursing Facility 120 days per calendar year. No day limitations for Inpatient Rehab Facility. Prior Authorization may be required.
	Durable medical equipment	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required for devices (purchase or cumulative rental) that cost more than \$1,000 per device.
	Hospice service	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required for Hospice Inpatient Only or benefit reduces to 50% of allowed. 8 bereavement visits per calendar year.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	1 routine exam every 24 months.
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This is not a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery (except for bariatric pilot program)
- 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 (This is not a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (limitations may apply)
- Hearing aids (limitations may apply)
- Routine eye care (Adult) (limitations may apply)

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-610-1863. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for medical claims under your plan, you may be able to **appeal** or file a **grievance**. 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 Healthways, Inc. 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.dch.georgia.gov/shbp.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-641-4862.

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Do not use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$2,840
- Patient pays \$4,700

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions*	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$3,500
Copays	\$0
Coinsurance	\$1,200
Limits or exclusions	\$0
Total	\$4,700

*Prescriptions are paid under the pharmacy benefit through Express Scripts, however, your member share is included in this calculation.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$1,450
- Patient pays \$3,950

Sample care costs:

Prescriptions*	\$2,900
Medical Equipment and Supplies*	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$3,500
Copays	\$0
Coinsurance	\$450
Limits or exclusions	\$0
Total	\$3,950

*Prescriptions, diabetic medical equipment and supplies are paid under the pharmacy benefit through Express Scripts, however, your member share is included in this calculation.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs do not include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and are not specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example Show

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment is not covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You cannot use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you will find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you will pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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