

 **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 www.dch.georgia.gov/shbp or by calling 1-888-364-6352.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	In-network: \$3,500 You / \$7,000 You + Family Out-of-network: \$7,000 You / \$14,000 You + Family / Per calendar year.	You must pay all the costs up to the deductible amount before this plan begins to pay for services you use. Check your policy or plan document to see when the deductible 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 deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Medical- In-network: \$6,450 You / \$12,900 You + Family Out-of-network: \$12,900 You / \$25,800 You + Family	The out-of-pocket limit is the most you could pay during a coverage period (usually a 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 out-of-pocket limit ?	Premium, balanced-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as limits on the number of office visits.
Does this plan use a network of providers ?	Yes. For a list of network providers , see www.welcometouhc.com/shbp or call 1-888-364-6352.	If you use a network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on Page 6. See your policy or plan document for additional information about excluded services .

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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 haven't 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 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</u> office or clinic	Primary care visit to treat an injury or illness	30% Coinsurance	50% Coinsurance	There are childhood obesity visit limits.
	Specialist visit	30% Coinsurance	50% Coinsurance	There are childhood obesity visit limits.
	Other practitioner office visit	30% Coinsurance	50% Coinsurance	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). 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	50% Coinsurance	Prior Authorization required for Sleep Studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	50% Coinsurance	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	See Pharmacy SBC.	See Pharmacy SBC.	See Pharmacy SBC. Medical and pharmacy out-of-pocket expenses are combined.
	Preferred brand drugs	See Pharmacy SBC.	See Pharmacy SBC.	See Pharmacy SBC. Medical and pharmacy out-of-pocket expenses are combined.
	Non-preferred brand drugs	See Pharmacy SBC.	See Pharmacy SBC.	See Pharmacy SBC. Medical and pharmacy out-of-pocket expenses are combined.
	Specialty Drugs	See Pharmacy SBC.	See Pharmacy SBC.	See Pharmacy SBC. Medical and pharmacy out-of-pocket expenses are combined.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	50% Coinsurance	Prior Authorization may be required.
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	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	30% Coinsurance	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	30% Coinsurance	---None---
	Urgent care	30% Coinsurance	50% Coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	50% Coinsurance	Prior Authorization required.
	Physician/surgeon fee	30% Coinsurance	50% Coinsurance	Some providers are not covered as an assistant at surgery. Prior Authorization may be required.

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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	Mental/Behavioral health outpatient services	30% Coinsurance	50% Coinsurance	Prior Authorization required or benefit reduces to 50% of allowed. Neuropsychological testing does not require Prior Authorization.
	Mental/Behavioral health inpatient services	30% Coinsurance	50% Coinsurance	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	50% Coinsurance	Prior Authorization required or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	30% Coinsurance	50% Coinsurance	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	50% Coinsurance	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	50% Coinsurance	Your cost for inpatient services only. For physician delivery charges, see pre-postnatal care. Prior Authorization may be required.

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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	Home health care	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Prior Authorization required for Home healthcare.
	Rehabilitation services	30% Coinsurance	50% Coinsurance	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.
	Habilitation services	30% Coinsurance	50% Coinsurance	Habilitation visits count toward the rehabilitation visit maximum above.
	Skilled nursing care	30% Coinsurance	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	50% Coinsurance	Prior Authorization required for devices (purchase or cumulative rental) that cost more than \$1,000 per device.
	Hospice service	30% Coinsurance	50% Coinsurance	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

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery (except for bariatric pilot program) • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"> • Chiropractic care limitations may apply • Hearing aids limitations may apply 	<ul style="list-style-type: none"> • Routine eye care (Adult) limitations may apply

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 questions about your eligibility, rights, this notice, or assistance, you can contact: the State Health Benefit Plan Call Center 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.**

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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.

Don't 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.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't 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 isn't 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 can't 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'll 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'll 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.