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://ambetter.pshpgeorgia.com/** or by calling **877-687-1180, TTY/TDD 877-941-9231**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6,800** individual / **$13,600** family. Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy plan 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, for network providers **$6,800** individual/**$13,600** family. No, for non-network providers.	The **out-of-pocket limit** 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 out–of–pocket limit?	Premiums, balance-billed charges, and non-network services 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 office visits.
Does this plan use a network of providers?	Yes. See Find a Provider or call **1-877-687-1180** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-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 don't need a referral to see a network specialist.	You can see the **specialist** you choose without permission from this plan; however, prior authorization is required 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 4. See your policy or plan document for additional information about **excluded services**.

- **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 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 provider's office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	Not covered	-----None-----
	Specialist visit	No charge after deductible	Not covered	Prior approval required.
	Other practitioner office visit	No charge after deductible	Not covered	-----None-----
	Preventive care/screening/immunization	No charge	Not covered	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	Not covered	Prior approval required.
	Imaging (CT/PET scans, MRIs)	No charge after deductible	Not covered	Prior approval required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Preferred Drug List .	Generic drugs	$20 Copay	Not covered	-----None-----
	Preferred brand drugs	No charge after deductible	Not covered	Prior approval required. Subject to deductible
	Non-preferred brand drugs	No charge after deductible	Not covered	
	Specialty drugs	No charge after deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not covered	Prior approval required.

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
	Physician/surgeon fees	No charge after deductible	Not covered	Prior approval required.
If you need immediate medical attention	Emergency room services	No charge after deductible	No charge after deductible	For Non-network Emergency service, you will be responsible for any balance billing charges.
	Emergency medical transportation	No charge after deductible	No charge after deductible	For Non-network Emergency service, you will be responsible for any balance billing charges.
	Urgent care	No charge after deductible	Not covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not covered	Prior approval required.
	Physician/surgeon fee	No charge after deductible	Not covered	Prior approval required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after deductible	Not covered	Prior approval required.
	Mental/Behavioral health inpatient services	No charge after deductible	Not covered	Prior approval required.
	Substance use disorder outpatient services	No charge after deductible	Not covered	Prior approval required.
	Substance use disorder inpatient services	No charge after deductible	Not covered	Prior approval required.
If you are pregnant	Prenatal and postnatal care	No charge after deductible	Not covered	Prior approval required.
	Delivery and all inpatient services	No charge after deductible	Not covered	Prior approval required. 48 hour minimum stay.

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	No charge after deductible	Not covered	Prior approval required. 120 Visit(s) per Year
	Rehabilitation services	No charge after deductible	Not covered	Prior approval required. 20 visits per year for ST; 20 visits per year combined for OT and PT.
	Habilitation services	No charge after deductible	Not covered	Prior approval required. 20 visits per year for ST; 20 visits per year combined for OT and PT.
	Skilled nursing care	No charge after deductible	Not covered	Prior approval required. 30 Days per year in a facility.
	Durable medical equipment	No charge after deductible	Not covered	Prior approval required.
	Hospice service	No charge after deductible	Not covered	Prior approval required.
If your child needs dental or eye care	Eye exam	$0 Copay/visit	Not covered	1 Visit per year
	Glasses	$0 Copay/visit	Not covered	1 Item per year
	Dental check-up	Not covered	Not covered	-----None-----

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 excluded services.)

- Abortion services (Except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Routine foot care (Not related to diabetes treatment)
- Acupuncture
- Dental Care (Adult)
- Private-duty nursing
- Bariatric surgery
- Long-term care
- Routine eye care (Adult)

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.)**		
• Chiropractic care (Limited to 40 specialists' visits per year combined with Speech, Physical and occupational Therapy) • Weight loss programs (4 Visits per year for nutritional counseling for treatment of obesity)	• Hearing aids (Cochlear implants only)	• Infertility treatment (Covered for the diagnosis of infertility only)

Your Rights to Continue Coverage

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 877-687-1180, TTY/TDD 877-941-9231. You may also contact your state insurance department at Georgia Office of Insurance and Safety Fire Commissioner, Two Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, Phone No. (404) 656-2070 or (800) 656-2298.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Georgia Office of Insurance and Safety Fire Commissioner, Two Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, Phone No. (404) 656-2070 or (800) 656-2298.

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 877-687-1180, TTY/TDD 877-941-9231
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-687-1180 (TDD/TTY: 877-941-9231).
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 877-687-1180 (TDD/TTY: 877-941-9231).

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

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 will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $540
- **Patient pays** $7,000

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	$6,800
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$7,000**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,120
- **Patient pays** $3,280

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	$2,400
Copays	$800
Coinsurance	$0
Limits or exclusions	$80
Total	**$3,280**

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 Examples 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.

Statement of Non-Discrimination

Ambetter from Peach State Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Peach State Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Peach State Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ambetter from Peach State Health Plan at 1-877-687-1180 (TTY/TDD 1-877-941-9231).

If you believe that Ambetter from Peach State Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from Peach State Health Plan Complaints Department, 1100 Circle 75 Parkway, Suite 1100, Atlanta, GA 30339, 1-877-687-1180 (TTY/TDD 1-877-941-9231), Fax 1-855-678-6982. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Peach State Health Plan is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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Spanish	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Ambetter from Peach State Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Peach State Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Peach State Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1180 (TTY/TDD 1-877-941-9231) 로 전화하십시오.
Chinese	如果您，或是您正在協助的對象，有關於 Ambetter from Peach State Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-877-687-1180 (TTY/TDD 1-877-941-9231)。
Gujarati	જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમાંથી કોઇને Ambetter from Peach State Health Plan વિશે પ્રશ્નો હોય તો તમને મદદ અને માહિતી મેળવવાનો અધિકાર છે. તે ખર્ચ વિના તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુભાષિયો વાત કરવા માટે 1-877-687-1180 (TTY/TDD 1-877-941-9231) પર કોલ કરો.
French	Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Ambetter from Peach State Health Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Amharic	እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Ambetter from Peach State Health Plan ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-877-687-1180 (TTY/TDD 1-877-941-9231) ይደውሉ።
Hindi	यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Ambetter from Peach State Health Plan के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी ि्भाषषए से बात करन े के लिए ,1-877-687-1180 (TTY/TDD 1-877-941-9231) पर किॉ करें।
French Creole-Haitian Creole	Si oumenm oswa yon moun w ap ede gen kesyon konsènan Ambetter from Peach State Health Plan, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-877-687-1180 (TTY/TDD 1-877-941-9231).

Russian	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Ambetter from Peach State Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Arabic	إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Ambetter from Peach State Health Plan ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Portuguese	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Peach State Health Plan, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Persian-Farsi	اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Ambetter from Peach State Health Plan ، داشته باشید حق این را دارید که کمکو اطلاعات به زبان خود را به طور رایگان دریافت نمایید 1-877-687-1180 (TTY/TDD 1-877-941-9231). تماس حاصل نمایید .
German	Falls Sie oder jemand, dem Sie helfen, Fragen zum Ambetter from Peach State Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1180 (TTY/TDD 1-877-941-9231) an.
Japanese	ご本人様、またはお客様の身の回りの方でも、Ambetter from Peach State Health Planについてご質問がございました ら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。 通訳とお話される場合、1-877-687-1180 (TTY/TDD 1-877-941-9231)までお電話ください