**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.uhc.com/shopmd** or by calling **1-877-856-2430.**

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: **$1,500** Indiv* **/ $3,000** Family Per calendar year. Does not apply to services listed below as "No Charge". * Doesn't apply if policy covers 2+ people. | 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 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, Network: **$6,000** Indiv* **/ $12,000** Family * Doesn't apply if policy covers 2+ people. | 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?** | Premium, balance-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 office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of **network providers**, see **www.uhc.com/shopmd** or call **1-877-856-2430.** | 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?** | Yes. An electronic approval is required to see a **Network** Specialist. | This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**. |
| **Are there services this plan does not cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call **1-877-856-2430** or visit us at **www.uhc.com/shopmd.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

- **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 only covers services if rendered by network **providers**. Exceptions include emergency services as described in your policy.

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider with referral | Your Cost If You Use a Network provider without referral | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 30% co-ins, after ded | Not Covered | Not Covered | Primary Physician must be assigned. Includes network OB/GYNs - no referral required. |
| | Specialist visit | 30% co-ins, after ded | Not Covered | Not Covered | Referrals must be from assigned Physician. |
| | Other practitioner office visit | 30% co-ins, after ded | Not Covered | Not Covered | Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. |
| | Preventive care / screening/im-munization | No Charge | Not Covered | Not Covered | Includes preventive health services specified in the health care reform law. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | None |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider with Referral | Your Cost If You Use a Network Provider without Referral | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.uhc.com/sho-pmd. | Tier 1 - Your Lowest-Cost Option | Retail: $10 copay, after ded<br>Mail-Order: $25 copay, after ded<br>Specialty Drugs: $10 copay, after ded | Retail: $10 copay, after ded<br>Mail-Order: $25 copay, after ded<br>Specialty Drugs: $10 copay, after ded | Not Covered | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 31 day supply.<br>Mail-Order: Up to a 90 day supply.<br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.<br>Certain drugs may have a Pre-Authorization requirement or may result in a higher cost.<br>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.<br>See the website listed for information on drugs covered by your plan. Not all drugs are covered.<br>Tier 1 contraceptives are covered at No Charge.<br>If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or co-ins may be applied. |
| | Tier 2 - Your Midrange-Cost Option | Retail: $40 copay, after ded<br>Mail-Order: $100 copay, after ded<br>Specialty Drugs: $100 copay, after ded | Retail: $40 copay, after ded<br>Mail-Order: $100 copay, after ded<br>Specialty Drugs: $100 copay, after ded | Not Covered | |
| | Tier 3 - Your Highest-Cost Option | Retail: $75 copay, after ded<br>Mail-Order: $187.50 copay, after ded<br>Specialty Drugs: $300 copay, after ded | Retail: $75 copay, after ded<br>Mail-Order: $187.50 copay, after ded<br>Specialty Drugs: $300 copay, after ded | Not Covered | |
| | Tier 4 (if applicable) - Additional High-Cost Options | Not Applicable | Not Applicable | Not Applicable | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% co-ins, after ded | Not Covered | Not Covered | None |
| | Physician/surgeon fees | 30% co-ins, after ded | Not Covered | Not Covered | None |
| **If you need immediate medical attention** | Emergency room services | 30% co-ins, after ded | 30% co-ins, after ded | 30% co-ins, after ded | None |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider with referral | Your Cost If You Use a Network Provider without referral | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| | Emergency medical transportation | 30% co-ins, after ded | 30% co-ins, after ded | 30% co-ins, after ded | None |
| | Urgent care | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% co-ins, after ded | Not Covered | Not Covered | None |
| | Physician/surgeon fees | 30% co-ins, after ded | Not Covered | Not Covered | None |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | None |
| | Mental/Behavioral health inpatient services | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | None |
| | Substance use disorder outpatient services | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | None |
| | Substance use disorder inpatient services | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | None |
| **If you are pregnant** | Prenatal and postnatal care | No Charge | No Charge | Not Covered | None |
| | Delivery and all inpatient services | 30% co-ins, after ded | Not Covered | Not Covered | None |
| **If you need help recovering or have other special health needs** | Home health care | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | None |
| | Rehabilitation services | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider with referral | Your Cost If You Use a Network Provider without referral | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| | Habilitative services | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | Services provided under and limits are combined with Rehabilitation services above. |
| | Skilled nursing care | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | Limited to 100 days per policy period (combined with Inpatient Rehabilitation) . |
| | Durable medical equipment | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | None |
| | Hospice service | 30% co-ins, after ded | 30% co-ins, after ded | Not Covered | None |
| **If your child needs dental or eye care** | Eye exam | 30% co-ins | 30% co-ins | Not Covered | One exam every 12 months. |
| | Glasses | 50% co-ins, after ded | 50% co-ins, after ded | Not Covered | One pair every 12 months. |
| | Dental check-up | 0% co-ins, after ded | 0% co-ins, after ded | Not Covered | Cleanings covered 2 times per 12 months. Additional limitations may apply. |

## 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.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment

## 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 1-866-747-1019. 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 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 the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or www.mdinsurance.state.md.us/sa. Additionally, a consumer assistance program can help you file your appeal. Contact Maryland Office of the Attorney General Health Education and Advocacy Unit at 1-877-261-8807 or TTY 1-800-576-6372 or visit www.oag.state.md.us/consumer.

## 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:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-856-2430

如果需要中文的帮助，**请拨打这个号码** 1-877-856-2430

Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-877-856-2430

Para obtener asistencia en Español, llame al 1-877-856-2430

*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** $4,120
- **Patient pays** $3,420

### 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 | $1,500 |
| Copays | $20 |
| Coinsurance | $1,700 |
| Limits or exclusions | $200 |
| **Total** | **$3,420** |

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

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

### 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 | $1,500 |
| Copays | $600 |
| Coinsurance | $100 |
| Limits or exclusions | $80 |
| **Total** | **$2,280** |

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

## 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.

**Questions:** Call **1-877-856-2430** or visit us at **www.uhc.com/shopmd.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.