# Silver Compass 4500 E

**Coverage Period: 01/01/2016 – 12/31/2016**

**Summary of Benefits and Coverage:** What This Plan Covers & What it Costs **Coverage for:** Individual & Family **Plan Type:** HMO

**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 uhc.com/individual-and-family/medical-policy or by calling 1-877-855-7435.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: **$3,250** individual / **$6,500** family<br><br>Per calendar year. Does not apply to services listed below with copays or "No Charge." | 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?** | Yes, Prescription drugs - **$1,000** per person. There are no other **deductibles**. | You must pay all the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| **Is there an out-of-pocket limit on my expenses?** | Network: **$5,200** individual / **$10,400** family | 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 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 **uhc.com/find-a-physician/xmdcompass** or call 1-877-855-7435. | 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 referral 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 doesn't 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 1-877-855-7435 or visit us at uhc.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above 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 a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-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 a Referral | Your Cost If You Use a Network Provider without a Referral | Your Cost If You Use a 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 | $10 copay per visit | Not Covered | Not Covered | Primary care provider (PCP) must be assigned. No referral required for OB/GYN.<br>Virtual visits (Telehealth) - $10 copay per visit by a designated virtual network provider.<br>If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. |
| | Specialist visit | $30 copay per visit | Not Covered | Not Covered | Referrals must be from assigned PCP. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. |
| | Other practitioner office visit | $30 copay per visit | Not Covered | Not Covered | Limited to 20 visits of manipulative (chiropractic) services per year. |
| | Preventive care / screening / immunization | No Charge | Not Covered | Not Covered | Includes preventive health services. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider with a Referral | Your Cost If You Use a Network Provider without a Referral | Your Cost If You Use a Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you have a test** | Diagnostic test (x-ray, blood work) | Freestanding: 0% co-ins after deductible | Freestanding: 0% co-ins after deductible | Not Covered | Hospital: 20% co-ins after deductible |
| | Imaging (CT / PET scans, MRIs) | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | Hospital: $400 imaging per occurrence. The $400 applies before the annual deductible. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at **uhc.com** | Tier 1 – Your Lowest-Cost Option | Retail: $5 copay | Retail: $5 copay | Not Covered | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 90 day supply.<br>Mail-Order: Not Covered<br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-authorization requirement or may result in a higher cost. If you use an out-of-network pharmacy, you may be responsible for any amount over the co-insurance amount. Tier 1 Contraceptives covered at No Charge. You may be required to use a lower-cost drug(s). Not all drugs are covered. Pharmacy Deductible does not apply to Tier 1 & 2. |
| | Tier 2 – Your Midrange-Cost Option | Retail: $40 copay | Retail: $40 copay | Not Covered | |
| | Tier 3 – Your Highest-Cost Option | Retail: $120 copay after deductible | Retail: $120 copay after deductible | Not Covered | |
| | Tier 4 – Additional High-Cost Options | Retail: $150 copay after deductible | Retail: $150 copay after deductible | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% co-ins after deductible | Not Covered | Not Covered | Hospital: $400 outpatient surgery per occurrence. The $400 applies before the annual deductible. |
| | Physician / surgeon fees | 0% co-ins after deductible | Not Covered | Not Covered | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider with a Referral | Your Cost If You Use a Network Provider without a Referral | Your Cost If You Use a Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | 0% co-ins after deductible | 0% co-ins after deductible | 0% co-ins after deductible | $500 emergency room per occurrence. The $500 applies before the annual deductible. |
| | Emergency medical transportation | 0% co-ins after deductible | 0% co-ins after deductible | 0% co-ins after deductible | ——————none—————— |
| | Urgent care | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% co-ins after deductible | Not Covered | Not Covered | ——————none—————— |
| | Physician / surgeon fees | 0% co-ins after deductible | Not Covered | Not Covered | ——————none—————— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental / Behavioral health outpatient services | $30 copay per visit | $30 copay per visit | Not Covered | Partial hospitalization/intensive outpatient treatment: 0% co-ins after deductible |
| | Mental / Behavioral health inpatient services | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | ——————none—————— |
| | Substance use disorder outpatient services | $30 copay per visit | $30 copay per visit | Not Covered | Partial hospitalization/intensive outpatient treatment: 0% co-ins after deductible |
| | Substance use disorder inpatient services | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | ——————none—————— |
| **If you are pregnant** | Prenatal and postnatal care | No Charge | No Charge | Not Covered | Additional copays, deductibles, or co-ins may apply. |
| | Delivery and all inpatient services | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | Inpatient authorization may apply. |
| **If you need help recovering or have other special health needs** | Home health care | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | ——————none—————— |
| | Rehabilitation services | $10 copay per visit | $10 copay per visit | Not Covered | Limits per calendar year: physical, speech, occupational – 30 visits; |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider with a Referral | Your Cost If You Use a Network Provider without a Referral | Your Cost If You Use a Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| | | | | | cardiac – 90 visits; pulmonary – 1 visit. |
| | Habilitative services | $10 copay per visit | $10 copay per visit | Not Covered | Limits per calendar year: physical, speech, occupational – 30 visits |
| | Skilled nursing care | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | Limited to 100 days per calendar year. (combined with Inpatient Rehabilitation) |
| | Durable medical equipment | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | ——————none—————— |
| | Hospice service | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | ——————none—————— |
| **If your child needs dental or eye care** | Eye exam | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | 1 exam every 12 months. |
| | Glasses | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | 1 pair every 12 months. Cost may increase depending on the frames. |
| | Dental check-up | 0% co-ins after deductible | 0% co-ins after deductible | Not Covered | Cleanings covered 2 times per 12 months. 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.)**

- Acupuncture
- 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 or plan document for other covered services and your costs for these services.)**

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

## 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 1-800-318-5311. You may also contact your state insurance department at Maryland Insurance Administration at 1-800-492-6116 or visit http://www.mdinsurance.state.md.us/sa/jsp/MIA.jsp.

## 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 Maryland Insurance Administration at 1-800-492-6116 or http://www.mdinsurance.state.md.us/sa/jsp/MIA.jsp.

Additionally, a consumer assistance program may 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 http://www.oag.state.md.us/Consumer/HEAU.htm.

## 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 1-877-855-7435.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-855-7435.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-855-7435.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-855-7435.

----------*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** $4,130
- **Patient pays** $3,410

**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 | $3,200 |
| Copays | $10 |
| Coinsurance | $0 |
| Limits or exclusions | $200 |
| **Total** | **$3,410** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,060
- **Patient pays** $1,340

**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 | $300 |
| Copays | $1,000 |
| Coinsurance | $0 |
| Limits or exclusions | $40 |
| **Total** | **$1,340** |

# Questions and answers about 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 to 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.

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