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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $3,500 Indiv* / $7,000 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, there are no other deductibles.	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: $6,250 Indiv* / $12,500 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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	40% co-ins, after ded	Not Covered	None
	Specialist visit	40% co-ins, after ded	Not Covered	None
	Other practitioner office visit	40% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	40% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	40% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	40% co-ins, after ded	40% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	40% co-ins, after ded	40% co-ins, after ded	None
	Urgent care	40% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	40% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	40% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	40% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	40% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	40% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	40% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	40% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	40% co-ins, after ded	Not Covered	None
	Rehabilitation services	40% 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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Habilitative Services	40% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	40% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	40% co-ins, after ded	Not Covered	None
	Hospice service	40% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	40% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $2,320**
- **Patient pays $5,220**

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
Co-pays	$20
Co-insurance	$1,500
Limits or exclusions	$200
Total	**$5,220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $1,520**
- **Patient pays $3,880**

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
Co-pays	$300
Co-insurance	$0
Limits or exclusions	$80
Total	**$3,880**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $4,000 Indiv* / $8,000 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, there are no other deductibles.	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: $6,250 Indiv* / $12,500 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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	None
	Specialist visit	30% co-ins, after ded	Not Covered	None
	Other practitioner office visit	30% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	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	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	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	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	30% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	30% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	Not Covered	None
	Rehabilitation services	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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Habilitative Services	30% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	30% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	30% co-ins, after ded	Not Covered	None
	Hospice service	30% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	30% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply.

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- Cosmetic surgery
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- Hearing aids - limitations may apply
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To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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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.

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $2,320**
- **Patient pays $5,220**

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	$4,000
Co-pays	$20
Co-insurance	$1,000
Limits or exclusions	$200
Total	**$5,220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $1,120**
- **Patient pays $4,280**

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	$4,000
Co-pays	$200
Co-insurance	$0
Limits or exclusions	$80
Total	**$4,280**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Optimum Choice, Inc. KV1/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $4,000 Indiv* / $8,000 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, there are no other deductibles.	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: $6,250 Indiv* / $12,500 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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	None
	Specialist visit	30% co-ins, after ded	Not Covered	None
	Other practitioner office visit	30% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	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	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	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	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	30% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	30% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	Not Covered	None
	Rehabilitation services	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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Habilitative Services	30% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	30% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	30% co-ins, after ded	Not Covered	None
	Hospice service	30% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	30% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $2,320**
- **Patient pays $5,220**

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	$4,000
Co-pays	$20
Co-insurance	$1,000
Limits or exclusions	$200
Total	**$5,220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $1,120**
- **Patient pays $4,280**

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	$4,000
Co-pays	$200
Co-insurance	$0
Limits or exclusions	$80
Total	**$4,280**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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UnitedHealthcare® **Optimum Choice, Inc. KV2/ZX**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $4,000 Indiv* / $8,000 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, there are no other deductibles.	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: $6,250 Indiv* / $12,500 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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	None
	Specialist visit	30% co-ins, after ded	Not Covered	None
	Other practitioner office visit	30% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	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	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay, after ded Mail-Order: $37.50 copay, after ded Specialty Drugs at Retail: $15 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : 30 % co-ins with a $100 copay max. Mail-Order: 30 % co-ins with a $250 copay max. Specialty Drugs at Retail: 30 % co-ins with a $100 copay max.	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : 50 % co-ins with a $300 copay max. Mail-Order: 50 % co-ins with a $750 copay max. Specialty Drugs at Retail: 50 % co-ins with a $300 copay max.	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	30% co-ins, after ded	30% co-ins, after ded	None
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	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	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	30% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	30% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	Not Covered	None
	Rehabilitation services	30% co-ins, after ded	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits.
	Habilitative Services	30% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	30% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	30% co-ins, after ded	Not Covered	None
	Hospice service	30% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	30% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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.**

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $2,320**
- **Patient pays $5,220**

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	$4,000
Co-pays	$20
Co-insurance	$1,000
Limits or exclusions	$200
Total	**$5,220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $1,020**
- **Patient pays $4,380**

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	$4,000
Co-pays	$300
Co-insurance	$0
Limits or exclusions	$80
Total	**$4,380**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $4,000 Indiv* / $8,000 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, there are no other deductibles.	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: $6,250 Indiv* / $12,500 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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	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	None
	Specialist visit	30% co-ins, after ded	Not Covered	None
	Other practitioner office visit	30% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	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	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay, after ded Mail-Order: $37.50 copay, after ded Specialty Drugs at Retail: $15 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : 30% co-ins with a $100 copay max. Mail-Order: 30% co-ins with a $250 copay max. Specialty Drugs at Retail: 30% co-ins with a $100 copay max.	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : 50% co-ins with a $300 copay max. Mail-Order: 50% co-ins with a $750 copay max. Specialty Drugs at Retail: 50% co-ins with a $300 copay max.	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	30% co-ins, after ded	30% co-ins, after ded	None
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	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	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	30% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	30% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	Not Covered	None
	Rehabilitation services	30% co-ins, after ded	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits.
	Habilitative Services	30% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	30% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	30% co-ins, after ded	Not Covered	None
	Hospice service	30% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	30% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply

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Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $2,320**
- **Patient pays $5,220**

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	$4,000
Co-pays	$20
Co-insurance	$1,000
Limits or exclusions	$200
Total	**$5,220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $1,020**
- **Patient pays $4,380**

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	$4,000
Co-pays	$300
Co-insurance	$0
Limits or exclusions	$80
Total	**$4,380**

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?

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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.

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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 **co-payments**, **deductibles**, and **co-insurance**. 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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Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $3,500 Indiv* / $7,000 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, there are no other deductibles.	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: $6,250 Indiv* / $12,500 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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	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	40% co-ins, after ded	Not Covered	None
	Specialist visit	40% co-ins, after ded	Not Covered	None
	Other practitioner office visit	40% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	40% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay, after ded Mail-Order: $37.50 copay, after ded Specialty Drugs at Retail: $15 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : 30% co-ins with a $100 copay max. Mail-Order: 30% co-ins with a $250 copay max. Specialty Drugs at Retail: 30% co-ins with a $100 copay max.	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : 50% co-ins with a $300 copay max. Mail-Order: 50% co-ins with a $750 copay max. Specialty Drugs at Retail: 50% co-ins with a $300 copay max.	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Physician/surgeon fees	40% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	40% co-ins, after ded	40% co-ins, after ded	None
	Emergency medical transportation	40% co-ins, after ded	40% co-ins, after ded	None
	Urgent care	40% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	40% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	40% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	40% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	40% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	40% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	40% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	40% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	40% co-ins, after ded	Not Covered	None
	Rehabilitation services	40% co-ins, after ded	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits.
	Habilitative Services	40% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	40% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	40% co-ins, after ded	Not Covered	None
	Hospice service	40% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	40% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

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Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $2,320**
- **Patient pays $5,220**

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
Co-pays	$20
Co-insurance	$1,500
Limits or exclusions	$200
Total	**$5,220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $1,420**
- **Patient pays $3,980**

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
Co-pays	$400
Co-insurance	$0
Limits or exclusions	$80
Total	**$3,980**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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UnitedHealthcare® **Optimum Choice, Inc. KV6/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $3,500 Indiv* / $7,000 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, there are no other deductibles.	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: $6,250 Indiv* / $12,500 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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	40% co-ins, after ded	Not Covered	None
	Specialist visit	40% co-ins, after ded	Not Covered	None
	Other practitioner office visit	40% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	40% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	40% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	40% co-ins, after ded	40% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	40% co-ins, after ded	40% co-ins, after ded	None
	Urgent care	40% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	40% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	40% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	40% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	40% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	40% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	40% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	40% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	40% co-ins, after ded	Not Covered	None
	Rehabilitation services	40% 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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Habilitative Services	40% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	40% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	40% co-ins, after ded	Not Covered	None
	Hospice service	40% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	40% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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.)

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- Private-duty nursing
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- Routine foot care
- Weight loss programs

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- Chiropractic care - limitations may apply
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Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $2,320**
- **Patient pays $5,220**

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
Co-pays	$20
Co-insurance	$1,500
Limits or exclusions	$200
Total	**$5,220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $1,520**
- **Patient pays $3,880**

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
Co-pays	$300
Co-insurance	$0
Limits or exclusions	$80
Total	**$3,880**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $4,000 Indiv* / $8,000 Family Non-Network: $6,000 Indiv* / $12,000 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, there are no other deductibles.	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: $6,250 Indiv* / $12,500 Family Non-Network: $15,000 Indiv* / $30,000 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 and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	50% co-ins, after ded	None
	Specialist visit	30% co-ins, after ded	50% co-ins, after ded	None
	Other practitioner office visit	30% co-ins, after ded	50% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Physician/surgeon fees	30% co-ins, after ded	50% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	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	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	30% co-ins, after ded	50% co-ins, after ded	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	30% co-ins, after ded	50% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	50% co-ins, after ded	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	50% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Rehabilitation services	30% co-ins, after ded	50% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Habilitative Services	30% co-ins, after ded	50% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	30% co-ins, after ded	50% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	30% co-ins, after ded	50% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	30% co-ins	50% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins, after ded	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

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Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $2,320**
- **Patient pays $5,220**

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	$4,000
Co-pays	$20
Co-insurance	$1,000
Limits or exclusions	$200
Total	**$5,220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $1,120**
- **Patient pays $4,280**

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	$4,000
Co-pays	$200
Co-insurance	$0
Limits or exclusions	$80
Total	**$4,280**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $2,000 Indiv / $4,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $250 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $6,250 Indiv/ $12,500 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$40 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$80 copay per visit	Not Covered	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$40 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 30% co-ins, after ded Hospital-Based: 30% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: 30% co-ins, after ded	Not Covered	$300 Free Standing Provider per occurrence deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Pharmacy Deductible does not apply to Tier 1. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: 30% co-ins, after ded	Not Covered	$300 Ambulatory Surg Center/Office per occurrence deductible.
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	30% co-ins, after ded	30% co-ins, after ded	None
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	$100 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$80 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$80 copay per visit	Not Covered	None
	Substance use disorder inpatient services	30% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	Not Covered	None
	Rehabilitation services	$40 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$40 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	30% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	30% co-ins, after ded	Not Covered	None
	Hospice service	30% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$40 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply

Your Rights to Continue Coverage:
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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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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.

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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.

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Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $3,740**
- **Patient pays $3,800**

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	$2,000
Co-pays	$0
Co-insurance	$1,600
Limits or exclusions	$200
Total	**$3,800**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,320**
- **Patient pays $2,080**

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	$1,400
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,080**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Choice LFG/ZT**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/Family | **Plan Type:** EP1

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $2,000 Indiv / $4,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $250 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $6,250 Indiv/ $12,500 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$60 copay per visit	Not Covered	Copay will only apply to Network with Referral. 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	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 40% co-ins, after ded Hospital-Based: 40% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 40% co-ins, after ded Hospital-Based: 40% co-ins, after ded	Not Covered	$300 Free Standing Provider per occurrence deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Pharmacy Deductible does not apply to Tier 1. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 40% co-ins, after ded Hospital-Based: 40% co-ins, after ded	Not Covered	$300 Ambulatory Surg Center/Office per occurrence deductible.
	Physician/surgeon fees	40% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	40% co-ins, after ded	40% co-ins, after ded	None
	Emergency medical transportation	40% co-ins, after ded	40% co-ins, after ded	None
	Urgent care	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	40% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$60 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	40% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$60 copay per visit	Not Covered	None
	Substance use disorder inpatient services	40% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	40% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	40% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	40% co-ins, after ded	Not Covered	None
	Rehabilitation services	$30 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$30 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	40% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	40% co-ins, after ded	Not Covered	None
	Hospice service	40% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$30 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $3,240**
- **Patient pays $4,300**

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	$2,000
Co-pays	$0
Co-insurance	$2,100
Limits or exclusions	$200
Total	**$4,300**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,320**
- **Patient pays $2,080**

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	$1,400
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,080**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $2,000 Indiv* / $4,000 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, there are no other deductibles.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	10% co-ins, after ded	Not Covered	None
	Specialist visit	10% co-ins, after ded	Not Covered	None
	Other practitioner office visit	10% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunizati-on	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	10% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	10% co-ins, after ded	10% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	10% co-ins, after ded	10% co-ins, after ded	None
	Urgent care	10% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	10% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	10% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	10% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	10% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	10% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	10% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	10% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	10% co-ins, after ded	Not Covered	None
	Rehabilitation services	10% 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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Habilitative Services	10% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	10% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	10% co-ins, after ded	Not Covered	None
	Hospice service	10% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	10% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $4,820**
- **Patient pays $2,720**

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	$2,000
Co-pays	$20
Co-insurance	$500
Limits or exclusions	$200
Total	**$2,720**

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

- **Amount owed to providers: $5,400**
- **Plan pays $2,820**
- **Patient pays $2,580**

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	$2,000
Co-pays	$500
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,580**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Choice KXS/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/Family | **Plan Type:** EP1

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.myuhc.com** 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, there are no other deductibles.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	20% co-ins, after ded	Not Covered	None
	Specialist visit	20% co-ins, after ded	Not Covered	None
	Other practitioner office visit	20% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunizati-on	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	20% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	20% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	20% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	20% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	20% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	Not Covered	None
	Rehabilitation services	20% 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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Habilitative Services	20% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	20% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	20% co-ins, after ded	Not Covered	None
	Hospice service	20% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	20% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply

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About these Coverage Examples:

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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 $4,620**
- **Patient pays $2,920**

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
Co-pays	$20
Co-insurance	$1,200
Limits or exclusions	$200
Total	**$2,920**

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
Co-pays	$600
Co-insurance	$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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $2,500 Indiv / $5,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $250 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $6,250 Indiv/ $12,500 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	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	$35 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$70 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$35 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: 20% co-ins, after ded	Not Covered	$300 Free Standing Provider per occurrence deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Pharmacy Deductible does not apply to Tier 1. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: 20% co-ins, after ded	Not Covered	$300 Ambulatory Surg Center/Office per occurrence deductible.
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	$100 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$70 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	20% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$70 copay per visit	Not Covered	None
	Substance use disorder inpatient services	20% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$35 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits.
	Habilitative Services	$35 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	20% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	20% co-ins, after ded	Not Covered	None
	Hospice service	20% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$35 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $3,840**
- **Patient pays $3,700**

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	$2,500
Co-pays	$0
Co-insurance	$1,000
Limits or exclusions	$200
Total	**$3,700**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,320**
- **Patient pays $2,080**

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	$1,400
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,080**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy. 8

UnitedHealthcare® **Optimum Choice, Inc. KXQ/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $2,000 Indiv* / $4,000 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, there are no other deductibles.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	10% co-ins, after ded	Not Covered	None
	Specialist visit	10% co-ins, after ded	Not Covered	None
	Other practitioner office visit	10% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunizati-on	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	10% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	10% co-ins, after ded	10% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	10% co-ins, after ded	10% co-ins, after ded	None
	Urgent care	10% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	10% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	10% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	10% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	10% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	10% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	10% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	10% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	10% co-ins, after ded	Not Covered	None
	Rehabilitation services	10% 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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Habilitative Services	10% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	10% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	10% co-ins, after ded	Not Covered	None
	Hospice service	10% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	10% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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)
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- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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- Acupuncture - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
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Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $4,820**
- **Patient pays $2,720**

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	$2,000
Co-pays	$20
Co-insurance	$500
Limits or exclusions	$200
Total	**$2,720**

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

- **Amount owed to providers: $5,400**
- **Plan pays $2,820**
- **Patient pays $2,580**

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	$2,000
Co-pays	$500
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,580**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Optimum Choice, Inc. KXU/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.welcometouhc.com** or by calling **1-866-673-6293.**

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, there are no other deductibles.	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 insurer 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.welcometouhc.com or call 1-866-673-6293.	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 can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-673-6293 or visit us at www.welcometouhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	20% co-ins, after ded	Not Covered	None
	Specialist visit	20% co-ins, after ded	Not Covered	None
	Other practitioner office visit	20% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunizati-on	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.welcometou-hc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	20% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	20% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	20% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	20% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	20% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	Not Covered	None
	Rehabilitation services	20% 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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Habilitative Services	20% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	20% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	20% co-ins, after ded	Not Covered	None
	Hospice service	20% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	20% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $4,620**
- **Patient pays $2,920**

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
Co-pays	$20
Co-insurance	$1,200
Limits or exclusions	$200
Total	**$2,920**

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
Co-pays	$600
Co-insurance	$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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** 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, there are no other deductibles.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	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	None
	Specialist visit	30% co-ins, after ded	Not Covered	None
	Other practitioner office visit	30% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	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	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	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	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	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	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	30% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	30% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	Not Covered	None
	Rehabilitation services	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	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Habilitative Services	30% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	30% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	30% co-ins, after ded	Not Covered	None
	Hospice service	30% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	30% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply.

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- Private-duty nursing
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- Routine foot care
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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
Co-pays	$20
Co-insurance	$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
Co-pays	$600
Co-insurance	$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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Optimum Choice, Inc. LF1/D0**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** 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 copays, prescription drugs, and services listed below as "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 - $500 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $6,250 Indiv/ $12,500 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?	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 insurer 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.myuhc.com 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. Written approval is required to see a 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 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$40 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$80 copay per visit	Not Covered	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$40 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 30% co-ins, after ded Hospital-Based: 30% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: 30% co-ins, after ded	Not Covered	$300 Free Standing Provider per occurrence deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Pharmacy Deductible does not apply to Tier 1. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: 30% co-ins, after ded	Not Covered	$300 Ambulatory Surg Center/Office per occurrence deductible.
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	30% co-ins, after ded	30% co-ins, after ded	None
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	$100 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$80 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$80 copay per visit	Not Covered	None
	Substance use disorder inpatient services	30% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	Not Covered	None
	Rehabilitation services	$40 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$40 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	30% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	30% co-ins, after ded	Not Covered	None
	Hospice service	30% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$40 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $4,140**
- **Patient pays $3,400**

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
Co-pays	$0
Co-insurance	$1,700
Limits or exclusions	$200
Total	**$3,400**

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	$1,600
Co-pays	$600
Co-insurance	$0
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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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UnitedHealthcare® **Optimum Choice, Inc. LF7/ZT**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $2,000 Indiv / $4,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $250 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $6,250 Indiv/ $12,500 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?	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 insurer 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.myuhc.com 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. Written approval is required to see a 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 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$40 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$80 copay per visit	Not Covered	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$40 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 30% co-ins, after ded Hospital-Based: 30% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: 30% co-ins, after ded	Not Covered	$300 Free Standing Provider per occurrence deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Pharmacy Deductible does not apply to Tier 1. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: 30% co-ins, after ded	Not Covered	$300 Ambulatory Surg Center/Office per occurrence deductible.
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	30% co-ins, after ded	30% co-ins, after ded	None
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	$100 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$80 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$80 copay per visit	Not Covered	None
	Substance use disorder inpatient services	30% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	Not Covered	None
	Rehabilitation services	$40 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$40 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	30% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	30% co-ins, after ded	Not Covered	None
	Hospice service	30% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$40 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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.

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $3,740**
- **Patient pays $3,800**

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	$2,000
Co-pays	$0
Co-insurance	$1,600
Limits or exclusions	$200
Total	**$3,800**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,320**
- **Patient pays $2,080**

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	$1,400
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,080**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $2,000 Indiv / $4,000 Family Non-Network: $4,000 Indiv / $8,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $250 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $6,250 Indiv/ $12,500 Family Non-Network: $10,000 Indiv/ $20,000 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	$40 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$80 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$40 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 30% co-ins, after ded Hospital-Based: 30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: 30% co-ins, after ded	50% co-ins, after ded	$300 Free Standing Provider per occurrence deductible. Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Pharmacy Deductible does not apply to Tier 1. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: 30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage. $300 Ambulatory Surg Center/Office per occurrence deductible.
	Physician/surgeon fees	30% co-ins, after ded	50% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	30% co-ins, after ded	30% co-ins, after ded	None
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	$100 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	30% co-ins, after ded	50% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$80 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	$80 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	50% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	50% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$40 copay per outpatient visit	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.
	Habilitative Services	$40 copay per outpatient visit	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	30% co-ins, after ded	50% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	30% co-ins, after ded	50% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	$40 copay per visit	20% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply

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Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $3,740**
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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	$2,000
Co-pays	$0
Co-insurance	$1,600
Limits or exclusions	$200
Total	**$3,800**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,320**
- **Patient pays $2,080**

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	$1,400
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,080**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $2,000 Indiv* / $4,000 Family Non-Network: $3,000 Indiv* / $6,000 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, there are no other deductibles.	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: $4,000 Indiv* / $8,000 Family Non-Network: $10,000 Indiv* / $20,000 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 and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	50% co-ins, after ded	None
	Specialist visit	30% co-ins, after ded	50% co-ins, after ded	None
	Other practitioner office visit	30% co-ins, after ded	50% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Physician/surgeon fees	30% co-ins, after ded	50% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	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	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	30% co-ins, after ded	50% co-ins, after ded	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	30% co-ins, after ded	50% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	50% co-ins, after ded	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	50% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Rehabilitation services	30% co-ins, after ded	50% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Habilitative Services	30% co-ins, after ded	50% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	30% co-ins, after ded	50% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	30% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	30% co-ins, after ded	50% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	30% co-ins	50% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins, after ded	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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.**

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $3,720**
- **Patient pays $3,820**

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	$2,000
Co-pays	$20
Co-insurance	$1,600
Limits or exclusions	$200
Total	**$3,820**

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

- **Amount owed to providers: $5,400**
- **Plan pays $2,720**
- **Patient pays $2,680**

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	$2,000
Co-pays	$500
Co-insurance	$100
Limits or exclusions	$80
Total	**$2,680**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $2,000 Indiv* / $4,000 Family Non-Network: $3,000 Indiv* / $6,000 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, there are no other deductibles.	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 Non-Network: $10,000 Indiv* / $20,000 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 and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	10% co-ins, after ded	30% co-ins, after ded	None
	Specialist visit	10% co-ins, after ded	30% co-ins, after ded	None
	Other practitioner office visit	10% co-ins, after ded	30% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Physician/surgeon fees	10% co-ins, after ded	30% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	10% co-ins, after ded	10% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	10% co-ins, after ded	10% co-ins, after ded	None
	Urgent care	10% co-ins, after ded	30% co-ins, after ded	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	10% co-ins, after ded	30% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	10% co-ins, after ded	30% co-ins, after ded	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	10% co-ins, after ded	30% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Rehabilitation services	10% co-ins, after ded	30% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Habilitative Services	10% co-ins, after ded	30% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	10% co-ins, after ded	30% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	10% co-ins, after ded	30% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	10% co-ins	30% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins, after ded	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	Cleanings covered 2 times per 12 months. Additional limitations may apply.

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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.

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $4,820**
- **Patient pays $2,720**

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	$2,000
Co-pays	$20
Co-insurance	$500
Limits or exclusions	$200
Total	**$2,720**

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

- **Amount owed to providers: $5,400**
- **Plan pays $2,820**
- **Patient pays $2,580**

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	$2,000
Co-pays	$500
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,580**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

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.myuhc.com** 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 Non-Network: $3,000 Indiv* / $6,000 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, there are no other deductibles.	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 Non-Network: $10,000 Indiv* / $20,000 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 and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	20% co-ins, after ded	40% co-ins, after ded	None
	Specialist visit	20% co-ins, after ded	40% co-ins, after ded	None
	Other practitioner office visit	20% co-ins, after ded	40% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Physician/surgeon fees	20% co-ins, after ded	40% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	20% co-ins, after ded	40% co-ins, after ded	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	20% co-ins, after ded	40% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	40% co-ins, after ded	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	40% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Rehabilitation services	20% co-ins, after ded	40% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Habilitative Services	20% co-ins, after ded	40% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	20% co-ins, after ded	40% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	20% co-ins, after ded	40% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	20% co-ins	40% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins, after ded	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $4,620**
- **Patient pays $2,920**

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
Co-pays	$20
Co-insurance	$1,200
Limits or exclusions	$200
Total	**$2,920**

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
Co-pays	$600
Co-insurance	$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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Choice LD5/ZS**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/Family | **Plan Type:** EP1

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,000 Indiv / $2,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $100 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $4,000 Indiv/ $8,000 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$25 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$50 copay per visit	Not Covered	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$25 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Free Standing Provider per occurrence deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Ambulatory Surg Center/Office per occurrence deductible.
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$50 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	20% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$50 copay per visit	Not Covered	None
	Substance use disorder inpatient services	20% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	Not Covered	None
	Rehabilitation services	$25 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$25 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	20% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	20% co-ins, after ded	Not Covered	None
	Hospice service	20% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$25 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply

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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 visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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.

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $5,040**
- **Patient pays $2,500**

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	$1,000
Co-pays	$0
Co-insurance	$1,300
Limits or exclusions	$200
Total	**$2,500**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,520**
- **Patient pays $1,880**

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	$1,100
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,880**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $500 Indiv / $1,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $4,500 Indiv/ $9,000 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$15 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. 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	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	20% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	20% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$30 copay per visit	Not Covered	None
	Substance use disorder inpatient services	20% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	Not Covered	None
	Rehabilitation services	$15 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$15 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	20% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	20% co-ins, after ded	Not Covered	None
	Hospice service	20% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$15 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply.

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

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- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
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- 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).

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $5,420**
- **Patient pays $2,120**

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	$500
Co-pays	$20
Co-insurance	$1,400
Limits or exclusions	$200
Total	**$2,120**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,020**
- **Patient pays $1,380**

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	$500
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,380**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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UnitedHealthcare® **Choice KW8/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/Family | **Plan Type:** EP1

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,300 Indiv* / $2,600 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, there are no other deductibles.	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: $2,600 Indiv* / $5,200 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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	0% co-ins, after ded	Not Covered	None
	Specialist visit	0% co-ins, after ded	Not Covered	None
	Other practitioner office visit	0% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	0% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	0% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	$250 copay per visit, after ded	$250 copay per visit, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	None
	Urgent care	0% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	0% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	0% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	0% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	0% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	0% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	0% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	0% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	Not Covered	None
	Rehabilitation services	0% 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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Habilitative Services	0% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	0% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	0% co-ins, after ded	Not Covered	None
	Hospice service	0% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $6,020**
- **Patient pays $1,520**

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	$1,300
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$1,520**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,420**
- **Patient pays $1,980**

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	$1,300
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,980**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Choice KWY/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/Family | **Plan Type:** EP1

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,300 Indiv* / $2,600 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, there are no other deductibles.	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: $2,600 Indiv* / $5,200 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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	10% co-ins, after ded	Not Covered	None
	Specialist visit	10% co-ins, after ded	Not Covered	None
	Other practitioner office visit	10% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunizati-on	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	10% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	10% co-ins, after ded	10% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	10% co-ins, after ded	10% co-ins, after ded	None
	Urgent care	10% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	10% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	10% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	10% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	10% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	10% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	10% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	10% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	10% co-ins, after ded	Not Covered	None
	Rehabilitation services	10% 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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Habilitative Services	10% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	10% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	10% co-ins, after ded	Not Covered	None
	Hospice service	10% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	10% co-ins	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
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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.

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $5,420**
- **Patient pays $2,120**

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	$1,300
Co-pays	$20
Co-insurance	$600
Limits or exclusions	$200
Total	**$2,120**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,420**
- **Patient pays $1,980**

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	$1,300
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,980**

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**, **co-payments**, and **co-insurance** 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.

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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 **co-payments**, **deductibles**, and **co-insurance**. 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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UnitedHealthcare® **Choice LE3/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,000 Indiv / $2,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $3,500 Indiv/ $7,000 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	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 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$60 copay per visit	Not Covered	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	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	20% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$60 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	20% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$60 copay per visit	Not Covered	None
	Substance use disorder inpatient services	20% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$30 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits.
	Habilitative Services	$30 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	20% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	20% co-ins, after ded	Not Covered	None
	Hospice service	20% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$30 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $5,020**
- **Patient pays $2,520**

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	$1,000
Co-pays	$20
Co-insurance	$1,300
Limits or exclusions	$200
Total	**$2,520**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,520**
- **Patient pays $1,880**

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	$1,000
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,880**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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UnitedHealthcare® **Choice LE9/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,000 Indiv / $2,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $3,000 Indiv/ $6,000 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	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	$20 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$40 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 10% co-ins, after ded Hospital-Based: 10% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 10% co-ins, after ded Hospital-Based: 10% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 10% co-ins, after ded Hospital-Based: 10% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	10% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	10% co-ins, after ded	10% co-ins, after ded	None
	Emergency medical transportation	10% co-ins, after ded	10% co-ins, after ded	None
	Urgent care	10% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	10% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$40 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	10% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$40 copay per visit	Not Covered	None
	Substance use disorder inpatient services	10% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	10% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	10% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	10% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$20 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits.
	Habilitative Services	$20 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	10% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
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- Long-term care
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- Acupuncture - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $5,720**
- **Patient pays $1,820**

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	$1,000
Co-pays	$20
Co-insurance	$600
Limits or exclusions	$200
Total	**$1,820**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,620**
- **Patient pays $1,780**

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	$1,000
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,780**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Optimum Choice, Inc. KW6/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,300 Indiv* / $2,600 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, there are no other deductibles.	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: $2,600 Indiv* / $5,200 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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	0% co-ins, after ded	Not Covered	None
	Specialist visit	0% co-ins, after ded	Not Covered	None
	Other practitioner office visit	0% co-ins, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	0% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	0% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	$250 copay per visit, after ded	$250 copay per visit, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	None
	Urgent care	0% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	0% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	0% co-ins, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	0% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	0% co-ins, after ded	Not Covered	None
	Substance use disorder inpatient services	0% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	0% co-ins, after ded	Not Covered	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	0% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	Not Covered	None
	Rehabilitation services	0% 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	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Habilitative Services	0% co-ins, after ded	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	0% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	0% co-ins, after ded	Not Covered	None
	Hospice service	0% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $6,020**
- **Patient pays $1,520**

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	$1,300
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$1,520**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,420**
- **Patient pays $1,980**

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	$1,300
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,980**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Optimum Choice, Inc. LD3/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** 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 copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $3,000 Indiv/ $6,000 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?	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 insurer 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.myuhc.com 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. Written approval is required to see a 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 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$60 copay per visit	Not Covered	Copay will only apply to Network with Referral. 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	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 30% co-ins, after ded Hospital-Based: 30% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: 30% co-ins, after ded	Not Covered	$250 Free Standing Provider per occurrence deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: 30% co-ins, after ded	Not Covered	$250 Ambulatory Surg Center/Office per occurrence deductible.
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	30% co-ins, after ded	30% co-ins, after ded	None
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	None
	Urgent care	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	None
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$60 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	30% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$60 copay per visit	Not Covered	None
	Substance use disorder inpatient services	30% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	30% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	30% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	Not Covered	None
	Rehabilitation services	$30 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$30 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	30% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	30% co-ins, after ded	Not Covered	None
	Hospice service	30% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$30 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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.

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $4,340**
- **Patient pays $3,200**

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
Co-pays	$0
Co-insurance	$1,500
Limits or exclusions	$200
Total	**$3,200**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,520**
- **Patient pays $1,880**

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	$1,100
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,880**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Optimum Choice, Inc. LE7/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,000 Indiv / $2,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $3,500 Indiv/ $7,000 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?	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 insurer 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.myuhc.com 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. Written approval is required to see a 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 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$60 copay per visit	Not Covered	Copay will only apply to Network with Referral. 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	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	20% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$60 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	20% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$60 copay per visit	Not Covered	None
	Substance use disorder inpatient services	20% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	Not Covered	None
	Rehabilitation services	$30 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$30 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	20% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	20% co-ins, after ded	Not Covered	None
	Hospice service	20% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$30 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply.

Excluded Services & Other Covered Services

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- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
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Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services).

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- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
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Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $5,020**
- **Patient pays $2,520**

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	$1,000
Co-pays	$20
Co-insurance	$1,300
Limits or exclusions	$200
Total	**$2,520**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,520**
- **Patient pays $1,880**

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	$1,000
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,880**

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**, **co-payments**, and **co-insurance** 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?

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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 **co-payments**, **deductibles**, and **co-insurance**. 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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UnitedHealthcare® **Optimum Choice, Inc. LEJ/ZS**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,000 Indiv / $2,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $100 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $4,000 Indiv/ $8,000 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?	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 insurer 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.myuhc.com 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. Written approval is required to see a 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 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$25 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$50 copay per visit	Not Covered	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$25 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Free Standing Provider per occurrence deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	Not Covered	$250 Ambulatory Surg Center/Office per occurrence deductible.
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	20% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$50 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	20% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$50 copay per visit	Not Covered	None
	Substance use disorder inpatient services	20% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	Not Covered	None
	Rehabilitation services	$25 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$25 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	20% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	20% co-ins, after ded	Not Covered	None
	Hospice service	20% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$25 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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.

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $5,040**
- **Patient pays $2,500**

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	$1,000
Co-pays	$0
Co-insurance	$1,300
Limits or exclusions	$200
Total	**$2,500**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,520**
- **Patient pays $1,880**

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	$1,100
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,880**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy. 8
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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,000 Indiv / $2,000 Family Non-Network: $2,000 Indiv / $4,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $100 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $4,000 Indiv/ $8,000 Family Non-Network: $6,000 Indiv/ $12,000 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	$25 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$50 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$25 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: 20% co-ins, after ded	40% co-ins, after ded	$250 Free Standing Provider per occurrence deductible. Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: 20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage. $250 Ambulatory Surg Center/Office per occurrence deductible.
	Physician/surgeon fees	20% co-ins, after ded	40% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	20% co-ins, after ded	40% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$50 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	$50 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	40% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	40% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$25 copay per outpatient visit	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.
	Habilitative Services	$25 copay per outpatient visit	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	20% co-ins, after ded	40% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	20% co-ins, after ded	40% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	$25 copay per visit	20% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	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
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Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services).

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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.

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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 $5,040**
- **Patient pays $2,500**

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	$1,000
Co-pays	$0
Co-insurance	$1,300
Limits or exclusions	$200
Total	**$2,500**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,520**
- **Patient pays $1,880**

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	$1,100
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,880**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Choice Plus LDU/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/Family | **Plan Type:** POS

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $500 Indiv / $1,000 Family Non-Network: $2,000 Indiv / $4,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $4,500 Indiv/ $9,000 Family Non-Network: $6,000 Indiv/ $12,000 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	$15 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$30 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	30% co-ins, after ded	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible. Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage. $250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	20% 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	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	20% co-ins, after ded	30% co-ins, after ded	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	20% co-ins, after ded	30% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	$30 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	30% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	30% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$15 copay per outpatient visit	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.
	Habilitative Services	$15 copay per outpatient visit	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	20% co-ins, after ded	30% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	20% co-ins, after ded	30% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	$15 copay per visit	20% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $5,420**
- **Patient pays $2,120**

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	$500
Co-pays	$20
Co-insurance	$1,400
Limits or exclusions	$200
Total	**$2,120**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,020**
- **Patient pays $1,380**

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	$500
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,380**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,000 Indiv / $2,000 Family Non-Network: $2,000 Indiv / $4,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $3,500 Indiv/ $7,000 Family Non-Network: $6,000 Indiv/ $12,000 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$60 copay per visit	20% co-ins, after ded	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	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	30% co-ins, after ded	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible. Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	
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	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 20% co-ins, after ded Hospital-Based: 20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage. $250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	20% 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	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-ins, after ded	20% co-ins, after ded	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	20% co-ins, after ded	30% co-ins, after ded	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	20% co-ins, after ded	30% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$60 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	$60 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	20% co-ins, after ded	30% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	30% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$30 copay per outpatient visit	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.
	Habilitative Services	$30 copay per outpatient visit	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	20% co-ins, after ded	30% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	20% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	20% co-ins, after ded	30% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	$30 copay per visit	20% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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.**

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Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $5,020**
- **Patient pays $2,520**

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	$1,000
Co-pays	$20
Co-insurance	$1,300
Limits or exclusions	$200
Total	**$2,520**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,520**
- **Patient pays $1,880**

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	$1,000
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,880**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Choice Plus LFC/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/Family | **Plan Type:** HMP

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,000 Indiv / $2,000 Family Non-Network: $2,000 Indiv / $4,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $3,000 Indiv/ $6,000 Family Non-Network: $6,000 Indiv/ $12,000 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	$20 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$40 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 10% co-ins, after ded Hospital-Based: 10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 10% co-ins, after ded Hospital-Based: 10% co-ins, after ded	30% co-ins, after ded	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible. Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 10% co-ins, after ded Hospital-Based: 10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage. $250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	10% 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	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	10% co-ins, after ded	10% co-ins, after ded	None
	Emergency medical transportation	10% co-ins, after ded	10% co-ins, after ded	None
	Urgent care	10% co-ins, after ded	30% co-ins, after ded	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	10% co-ins, after ded	30% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$40 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	$40 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	10% co-ins, after ded	30% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	10% co-ins, after ded	30% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$20 copay per outpatient visit	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.
	Habilitative Services	$20 copay per outpatient visit	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	10% co-ins, after ded	30% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	10% co-ins, after ded	30% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	$20 copay per visit	20% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	Cleanings covered 2 times per 12 months. Additional limitations may apply.

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

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Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $5,720**
- **Patient pays $1,820**

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	$1,000
Co-pays	$20
Co-insurance	$600
Limits or exclusions	$200
Total	**$1,820**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,620**
- **Patient pays $1,780**

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	$1,000
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,780**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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- 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**, **co-payments**, and **co-insurance** 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?

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Are there other costs I should consider when comparing plans?

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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,300 Indiv* / $2,600 Family Non-Network: $2,000 Indiv* / $4,000 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, there are no other deductibles.	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: $2,600 Indiv* / $5,200 Family Non-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 and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	10% co-ins, after ded	30% co-ins, after ded	None
	Specialist visit	10% co-ins, after ded	30% co-ins, after ded	None
	Other practitioner office visit	10% co-ins, after ded	30% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	Retail : $75 copay, after ded Mail-Order: $187.50 copay, after ded Specialty Drugs at Retail: $300 copay, after ded	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Physician/surgeon fees	10% co-ins, after ded	30% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	10% co-ins, after ded	10% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	10% co-ins, after ded	10% co-ins, after ded	None
	Urgent care	10% co-ins, after ded	30% co-ins, after ded	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	10% co-ins, after ded	30% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	10% co-ins, after ded	30% co-ins, after ded	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	10% co-ins, after ded	30% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Rehabilitation services	10% co-ins, after ded	30% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Habilitative Services	10% co-ins, after ded	30% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	10% co-ins, after ded	30% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	10% co-ins, after ded	30% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	10% co-ins	30% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins, after ded	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $5,420**
- **Patient pays $2,120**

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	$1,300
Co-pays	$20
Co-insurance	$600
Limits or exclusions	$200
Total	**$2,120**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,420**
- **Patient pays $1,980**

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	$1,300
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,980**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,300 Indiv* / $2,600 Family Non-Network: $2,000 Indiv* / $4,000 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, there are no other deductibles.	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: $2,600 Indiv* / $5,200 Family Non-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 and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	0% co-ins, after ded	20% co-ins, after ded	None
	Specialist visit	0% co-ins, after ded	20% co-ins, after ded	None
	Other practitioner office visit	0% co-ins, after ded	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Retail : $10 copay, after ded Mail-Order: $25 copay, after ded Specialty Drugs at Retail: $10 copay, after ded	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	Retail : $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs at Retail: $100 copay, after ded	
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	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	$250 copay per visit, after ded	$250 copay per visit, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	None
	Urgent care	0% co-ins, after ded	20% co-ins, after ded	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	0% co-ins, after ded	20% co-ins, after ded	Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	0% co-ins, after ded	20% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Rehabilitation services	0% co-ins, after ded	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Habilitative Services	0% co-ins, after ded	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	0% co-ins, after ded	20% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	0% co-ins, after ded	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	No Charge	20% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins, after ded	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

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Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $6,020**
- **Patient pays $1,520**

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	$1,300
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$1,520**

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,420**
- **Patient pays $1,980**

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	$1,300
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,980**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	Yes, prescription drugs - $50 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $3,000 Indiv/ $6,000 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$20 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Specialist visit	$60 copay per visit	Not Covered	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	$100 Free Standing Provider per occurrence deductible. $300 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: No Charge	Not Covered	$100 Ambulatory Surg Center/Office per occurrence deductible. $300 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$60 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	No Charge	Not Covered	None
	Substance use disorder outpatient services	$60 copay per visit	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Additional copays, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	No Charge	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$20 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$20 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	No Charge	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	No Charge	Not Covered	None
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Eye exam	$20 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply. Dental Deductible: Network: $100 Indiv / $200 Family

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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit www.cciio.cms.gov.

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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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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.

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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 $7,340**
- **Patient pays $200**

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	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$200
Total	**$200**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,120**
- **Patient pays $1,280**

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	$100
Co-pays	$1,100
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,280**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $250 Indiv / $500 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $3,000 Indiv/ $6,000 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$15 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. 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	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 0% co-ins, after ded Hospital-Based: 0% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 0% co-ins, after ded Hospital-Based: 0% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 0% co-ins, after ded Hospital-Based: 0% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	0% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	0% co-ins, after ded	0% co-ins, after ded	None
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	None
	Urgent care	0% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	0% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	0% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$30 copay per visit	Not Covered	None
	Substance use disorder inpatient services	0% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	0% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	0% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	Not Covered	None
	Rehabilitation services	$15 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$15 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	0% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	0% co-ins, after ded	Not Covered	None
	Hospice service	0% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$15 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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.

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $7,020**
- **Patient pays $520**

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	$300
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$520**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,320**
- **Patient pays $1,080**

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	$200
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,080**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	No, there are no other deductibles.	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: $5,000 Indiv/ $10,000 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$15 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Specialist visit	$30 copay per visit	Not Covered	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	$150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: No Charge	Not Covered	$150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	No Charge	Not Covered	None
	Substance use disorder outpatient services	$30 copay per visit	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Additional copays, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	No Charge	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$15 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$15 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	No Charge	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	No Charge	Not Covered	None
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Eye exam	$15 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply. Dental Deductible: Network: $100 Indiv / $200 Family

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.)

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- Dental care (Adult)
- Long-term care
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- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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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.

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Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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.

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $7,320**
- **Patient pays $220**

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	$0
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,220**
- **Patient pays $1,180**

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	$0
Co-pays	$1,100
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,180**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	No, there are no other deductibles.	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: $3,000 Indiv/ $6,000 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	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	$20 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Specialist visit	$40 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	$75 Free Standing Provider per occurrence deductible. $150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: No Charge	Not Covered	$75 Ambulatory Surg Center/Office per occurrence deductible. $150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$40 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	No Charge	Not Covered	None
	Substance use disorder outpatient services	$40 copay per visit	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Additional copays, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	No Charge	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	None
	Rehabilitation services	$20 copay per outpatient visit	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	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Habilitative Services	$20 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	No Charge	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	No Charge	Not Covered	None
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Eye exam	$20 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply. Dental Deductible: Network: $100 Indiv / $200 Family

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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $7,320**
- **Patient pays $220**

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	$0
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,220**
- **Patient pays $1,180**

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	$0
Co-pays	$1,100
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,180**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	Yes, prescription drugs - $50 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $3,000 Indiv/ $6,000 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	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	$15 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Specialist visit	$30 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	$150 Free Standing Provider per occurrence deductible. $300 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: No Charge	Not Covered	$150 Ambulatory Surg Center/Office per occurrence deductible. $300 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	$250 copay per visit	$250 copay per visit	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per day up to a maximum of $1,500 per admission.	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	$500 copay per day up to a maximum of $1,500 per admission.	Not Covered	None
	Substance use disorder outpatient services	$30 copay per visit	Not Covered	None
	Substance use disorder inpatient services	$500 copay per day up to a maximum of $1,500 per admission.	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Additional copays, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Delivery and all inpatient services	$500 copay per day up to a maximum of $1,500 per admission.	Not Covered	Additional copays, co-ins may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	None
	Rehabilitation services	$15 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits.
	Habilitative Services	$15 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	$500 copay per day up to a maximum of $1,500 per admission.	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	No Charge	Not Covered	None
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Eye exam	$15 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply. Dental Deductible: Network: $100 Indiv / $200 Family

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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply

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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.**

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $6,840**
- **Patient pays $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	$0
Co-pays	$500
Co-insurance	$0
Limits or exclusions	$200
Total	**$700**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,420**
- **Patient pays $980**

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	$100
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$980**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	No, there are no other deductibles.	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: $3,000 Indiv/ $6,000 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?	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 insurer 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.myuhc.com 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. Written approval is required to see a 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 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$20 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Specialist visit	$40 copay per visit	Not Covered	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	$75 Free Standing Provider per occurrence deductible. $150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: No Charge	Not Covered	$75 Ambulatory Surg Center/Office per occurrence deductible. $150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$40 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	No Charge	Not Covered	None
	Substance use disorder outpatient services	$40 copay per visit	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Additional copays, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	No Charge	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$20 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$20 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	No Charge	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	No Charge	Not Covered	None
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Eye exam	$20 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply. Dental Deductible: Network: $100 Indiv / $200 Family

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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $7,320**
- **Patient pays $220**

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	$0
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,220**
- **Patient pays $1,180**

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	$0
Co-pays	$1,100
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,180**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

UnitedHealthcare® **Optimum Choice, Inc. LG4/YM**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $250 Indiv / $500 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $3,000 Indiv/ $6,000 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?	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 insurer 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.myuhc.com 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. Written approval is required to see a 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 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$15 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. 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	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 0% co-ins, after ded Hospital-Based: 0% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 0% co-ins, after ded Hospital-Based: 0% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 0% co-ins, after ded Hospital-Based: 0% co-ins, after ded	Not Covered	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	0% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	0% co-ins, after ded	0% co-ins, after ded	None
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	None
	Urgent care	0% co-ins, after ded	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	0% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	0% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$30 copay per visit	Not Covered	None
	Substance use disorder inpatient services	0% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	0% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	0% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	Not Covered	None
	Rehabilitation services	$15 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$15 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	0% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	0% co-ins, after ded	Not Covered	None
	Hospice service	0% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$15 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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
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Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services).

- Acupuncture - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply

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Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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

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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 $7,020**
- **Patient pays $520**

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	$300
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$520**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,320**
- **Patient pays $1,080**

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	$200
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,080**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	Yes, prescription drugs - $50 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $3,000 Indiv/ $6,000 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?	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 insurer 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.myuhc.com 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. Written approval is required to see a 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 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$15 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Specialist visit	$30 copay per visit	Not Covered	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	$150 Free Standing Provider per occurrence deductible. $300 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: No Charge	Not Covered	$150 Ambulatory Surg Center/Office per occurrence deductible. $300 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per day up to a maximum of $1,500 per admission.	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	$500 copay per day up to a maximum of $1,500 per admission.	Not Covered	None
	Substance use disorder outpatient services	$30 copay per visit	Not Covered	None
	Substance use disorder inpatient services	$500 copay per day up to a maximum of $1,500 per admission.	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Additional copays, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	$500 copay per day up to a maximum of $1,500 per admission.	Not Covered	Additional copays, co-ins may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	None
	Rehabilitation services	$15 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$15 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	$500 copay per day up to a maximum of $1,500 per admission.	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	No Charge	Not Covered	None
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Eye exam	$15 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Dental check-up	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply. Dental Deductible: Network: $100 Indiv / $200 Family

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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $6,840**
- **Patient pays $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	$0
Co-pays	$500
Co-insurance	$0
Limits or exclusions	$200
Total	**$700**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,420**
- **Patient pays $980**

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	$100
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$980**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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UnitedHealthcare® **Optimum Choice, Inc. LHP/ZU**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 - 12/31/2014

Coverage for: Employee/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 **www.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	No, there are no other deductibles.	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: $5,000 Indiv/ $10,000 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?	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 insurer 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.myuhc.com 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. Written approval is required to see a 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 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	Your cost if you use a Preferred and 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	$15 copay per visit	Not Covered	Copay will only apply to member's assigned Primary Care Physician. If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Specialist visit	$30 copay per visit	Not Covered	Copay will only apply to Network with Referral. If you receive services in addition to office visit, additional copays, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: No Charge	Not Covered	$150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: No Charge	Not Covered	$150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	No Charge	Not Covered	None
	Substance use disorder outpatient services	$30 copay per visit	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Additional copays, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	No Charge	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Preferred and Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$15 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits.
	Habilitative Services	$15 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	No Charge	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	No Charge	Not Covered	None
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Eye exam	$15 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	Not Covered	Cleanings covered 2 times per 12 months. Additional limitations may apply. Dental Deductible: Network: $100 Indiv / $200 Family

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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $7,320**
- **Patient pays $220**

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	$0
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,220**
- **Patient pays $1,180**

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	$0
Co-pays	$1,100
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,180**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $250 Indiv / $500 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $50 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $2,500 Indiv/ $5,000 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?	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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	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	$10 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$20 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$10 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	10% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	10% co-ins, after ded	10% co-ins, after ded	None
	Emergency medical transportation	10% co-ins, after ded	10% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Urgent care	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins, after ded	Not Covered	None
	Physician/surgeon fees	10% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$20 copay per visit	Not Covered	None
	Mental/Behavioral health inpatient services	10% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$20 copay per visit	Not Covered	None
	Substance use disorder inpatient services	10% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	10% co-ins, after ded	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	10% co-ins, after ded	Not Covered	Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	10% co-ins, after ded	Not Covered	None
	Rehabilitation services	$10 copay per outpatient visit	Not Covered	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits.
	Habilitative Services	$10 copay per outpatient visit	Not Covered	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	10% co-ins, after ded	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	10% co-ins, after ded	Not Covered	None
	Hospice service	10% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$10 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins	Not Covered	One pair every 12 months.
	Dental check-up	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6,440**
- **Patient pays $1,100**

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	$300
Co-pays	$0
Co-insurance	$600
Limits or exclusions	$200
Total	**$1,100**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,020**
- **Patient pays $1,380**

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
Co-pays	$1,000
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,380**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $0 Non-Network: $1,000 Indiv / $2,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $50 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $3,000 Indiv/ $6,000 Family Non-Network: $6,000 Indiv/ $12,000 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	$20 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$60 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: No Charge	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: No Charge	20% co-ins, after ded	$100 Free Standing Provider per occurrence deductible. $300 Hospital-Based per occurrence deductible applies prior to the Annual Deductible. Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: No Charge	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage. $100 Ambulatory Surg Center/Office per occurrence deductible. $300 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	No Charge	20% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$60 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	$60 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	No Charge	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	No Charge	20% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$20 copay per outpatient visit	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.
	Habilitative Services	$20 copay per outpatient visit	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	No Charge	20% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	No Charge	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	$20 copay per visit	20% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	Cleanings covered 2 times per 12 months. Additional limitations may apply. Dental Deductible: Network: $100 Indiv / $200 Family

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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

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Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $7,340**
- **Patient pays $200**

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	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$200
Total	**$200**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,120**
- **Patient pays $1,280**

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	$100
Co-pays	$1,100
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,280**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $0 Non-Network: $1,000 Indiv / $2,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $3,000 Indiv/ $6,000 Family Non-Network: $6,000 Indiv/ $12,000 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	$20 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$40 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: No Charge	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: No Charge	20% co-ins, after ded	$75 Free Standing Provider per occurrence deductible. $150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible. Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	
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	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: No Charge	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage. $75 Ambulatory Surg Center/Office per occurrence deductible. $150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	No Charge	20% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$40 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	$40 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	No Charge	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	No Charge	20% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$20 copay per outpatient visit	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.
	Habilitative Services	$20 copay per outpatient visit	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	No Charge	20% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	No Charge	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	$20 copay per visit	20% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	Cleanings covered 2 times per 12 months. Additional limitations may apply. Dental Deductible: Network: $100 Indiv / $200 Family

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.)

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- Dental care (Adult)
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- 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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
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Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $7,320**
- **Patient pays $220**

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	$0
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,220**
- **Patient pays $1,180**

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	$0
Co-pays	$1,100
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,180**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $250 Indiv / $500 Family Non-Network: $2,000 Indiv / $4,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $3,000 Indiv/ $6,000 Family Non-Network: $6,000 Indiv/ $12,000 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	$15 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$30 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: 0% co-ins, after ded Hospital-Based: 0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: 0% co-ins, after ded Hospital-Based: 0% co-ins, after ded	20% co-ins, after ded	$250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible. Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: 0% co-ins, after ded Hospital-Based: 0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage. $250 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	0% co-ins, after ded	0% co-ins, after ded	None
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	None
	Urgent care	0% co-ins, after ded	20% co-ins, after ded	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	$30 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	0% co-ins, after ded	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	0% co-ins, after ded	20% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$15 copay per outpatient visit	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.
	Habilitative Services	$15 copay per outpatient visit	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	0% co-ins, after ded	20% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	0% co-ins, after ded	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	$15 copay per visit	20% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $7,020**
- **Patient pays $520**

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	$300
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$520**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,320**
- **Patient pays $1,080**

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	$200
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,080**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $0 Non-Network: $1,000 Indiv / $2,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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?	No, there are no other deductibles.	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: $5,000 Indiv/ $10,000 Family Non-Network: $6,000 Indiv/ $12,000 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	$15 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$30 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: No Charge	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: No Charge	20% co-ins, after ded	$150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible. Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: No Charge	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage. $150 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	No Charge	20% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	$30 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	No Charge	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	No Charge	20% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation services	$15 copay per outpatient visit	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.
	Habilitative Services	$15 copay per outpatient visit	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	No Charge	20% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	No Charge	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	$15 copay per visit	20% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	Cleanings covered 2 times per 12 months. Additional limitations may apply. Dental Deductible: Network: $100 Indiv / $200 Family

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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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.**

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若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $7,320**
- **Patient pays $220**

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	$0
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,220**
- **Patient pays $1,180**

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	$0
Co-pays	$1,100
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,180**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy. 8

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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $0 Non-Network: $4,000 Indiv / $8,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $50 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $3,000 Indiv/ $6,000 Family Non-Network: $10,000 Indiv/ $20,000 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

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- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	$15 copay per visit	20% co-ins, after ded	Copay will only apply to member's assigned Primary Care Physician. Otherwise Preferred cost share will apply. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$30 copay per visit	20% co-ins, after ded	Copay will only apply to Network with Referral. Otherwise Preferred cost share will apply. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage
	Preventive care/screening/ immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Provider: No Charge Hospital-Based: No Charge	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	Free Standing Provider: No Charge Hospital-Based: No Charge	20% co-ins, after ded	$150 Free Standing Provider per occurrence deductible. $300 Hospital-Based per occurrence deductible applies prior to the Annual Deductible. Pre-Authorization required for non-network or no coverage

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Retail : $10 copay Mail-Order: $25 copay Specialty Drugs at Retail: $10 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	Retail : $40 copay Mail-Order: $100 copay Specialty Drugs at Retail: $100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	Retail : $75 copay Mail-Order: $187.50 copay Specialty Drugs at Retail: $300 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center / Office: No Charge Hospital-Based: No Charge	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage. $150 Ambulatory Surg Center/Office per occurrence deductible. $300 Hospital-Based per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per day up to a maximum of $1,500 per admission.	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage
	Physician/surgeon fees	No Charge	20% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$30 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	$500 copay per day up to a maximum of $1,500 per admission.	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage
	Substance use disorder outpatient services	$30 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage
	Substance use disorder inpatient services	$500 copay per day up to a maximum of $1,500 per admission.	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No Charge	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	$500 copay per day up to a maximum of $1,500 per admission.	20% co-ins, after ded	Additional copays, deductibles, co-ins and inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	20% co-ins, after ded	None
	Rehabilitation services	$15 copay per outpatient visit	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Habilitative Services	$15 copay per outpatient visit	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Depending upon the type of service Pre-Authorization may be required for non-network or no coverage.
	Skilled nursing care	$500 copay per day up to a maximum of $1,500 per admission.	20% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage
	Durable medical equipment	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Hospice service	No Charge	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	$15 copay per visit	20% co-ins, after ded	One exam every 12 months.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Glasses	50% co-ins	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	Cleanings covered 2 times per 12 months. Additional limitations may apply. Dental Deductible: Network: $100 Indiv / $200 Family

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)
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Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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

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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 $6,840**
- **Patient pays $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	$0
Co-pays	$500
Co-insurance	$0
Limits or exclusions	$200
Total	**$700**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,420**
- **Patient pays $980**

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	$100
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$980**

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**, **co-payments**, and **co-insurance** 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?

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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 **co-payments**, **deductibles**, and **co-insurance**. 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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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.myuhc.com** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $250 Indiv / $500 Family Non-Network: $1,000 Indiv / $2,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "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 - $50 Indiv There are no other specific deductibles.	You must pay all of 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?	Yes, Network: $2,500 Indiv/ $5,000 Family Non-Network: $6,000 Indiv/ $12,000 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?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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 insurer 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.myuhc.com 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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-856-2430 or visit us at www.myuhc.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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	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	$10 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$20 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$10 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or no coverage.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or no coverage.
	Imaging (CT/PET scans, MRIs)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.myuhc.com.	Tier 1 - Your Lowest-Cost Option	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Retail : $15 copay Mail-Order: $37.50 copay Specialty Drugs at Retail: $15 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. 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 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	Retail : $25 copay Mail-Order: $62.50 copay Specialty Drugs at Retail: $100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	Retail : $50 copay Mail-Order: $125 copay Specialty Drugs at Retail: $300 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Physician/surgeon fees	10% co-ins, after ded	30% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	10% co-ins, after ded	10% co-ins, after ded	None
	Emergency medical transportation	10% co-ins, after ded	10% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Urgent care	$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Physician/surgeon fees	10% co-ins, after ded	30% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	$20 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Mental/Behavioral health inpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Substance use disorder outpatient services	$20 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or no coverage.
	Substance use disorder inpatient services	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage
If you are pregnant	Prenatal and postnatal care	10% co-ins, after ded	30% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	10% co-ins, after ded	30% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network or no coverage.
	Rehabilitation services	$10 copay per outpatient visit	20% co-ins, after ded	Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac 90 visits. Pre-Authorization required for certain services for non-network or no coverage.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Habilitative Services	$10 copay per outpatient visit	20% co-ins, after ded	Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or no coverage.
	Skilled nursing care	10% co-ins, after ded	30% co-ins, after ded	Limited to 100 days per policy period. Pre-Authorization required for non-network or no coverage.
	Durable medical equipment	10% co-ins, after ded	30% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	10% co-ins, after ded	30% co-ins, after ded	Inpatient Pre-Authorization required for non-network or no coverage.
If your child needs dental or eye care	Eye exam	$10 copay per visit	20% co-ins, after ded	One exam every 12 months.
	Glasses	50% co-ins	50% co-ins, after ded	One pair every 12 months.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	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 - limitations may apply
- Bariatric surgery - limitations may apply
- Chiropractic care - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - 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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit 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:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.
若需要中文协助，请拨打本文件内的客户服务电话。
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

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 $6,440**
- **Patient pays $1,100**

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	$300
Co-pays	$0
Co-insurance	$600
Limits or exclusions	$200
Total	**$1,100**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,020**
- **Patient pays $1,380**

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
Co-pays	$1,000
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,380**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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