UnitedHealthcare of the Mid-Atlantic, Inc.

Silver Compass HSA 150

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

Coverage Period: 1/1/2015 – 12/31/2015

Coverage for: Individual | **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.uhc.com/xmd or by calling 1-877-855-7435.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network**: **$150** Individual / **$300** Family Per calendar year. Doesn't apply to prescription drugs, services list below with **copayments** and "No charge"	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes**, **Network**: **$2,250** person / **$4,500** family per calendar year. **No**, **Non-network**	**Network**: The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for healthcare expenses. **Non-network**: There's no limit on how much you could pay during a policy period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	Premiums, **balance-billed** charges, and health care this plan doesn't cover and penalties for failure to obtain pre-authorizations for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	**No**, this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 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**, this plan uses **network providers**. If you use a non-network **provider** your cost will be more. For a list of network **providers**, see www.myuhc.com or call 1-877-855-7435 for a list of network **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to **providers** in their network.
Do I need a referral to see a specialist?	**No.**	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5.

Questions: Call 1-877-855-7435 or visit us at www.uhc.com/xmd.

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 call 1-877-855-7435 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an 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 **copayments**, **deductible** or **coinsurance** may apply.
	Specialist visit	$30 **copay** per visit	Not covered	If you receive services in addition to office visit, additional **copayments**, **deductible** or **coinsurance** may apply.
	Other practitioner office visit	$30 **copay** per visit	Not covered	If you receive services in addition to office visit, additional **copayments**, **deductible** or **coinsurance** may apply. The following are limited per person per calendar year: manipulative treatment - 20 visits per condition; physical, speech and occupational therapy - 30 visits per condition per type of therapy; cardiac rehabilitation - 90 visits.
	Preventive care/screening/immunization	No charge	Not covered	Includes preventive health services specified in the health care reform law. No coverage for non-network.
If you have a test	Diagnostic test (x-ray, blood work)	Freestanding: 0% **coinsurance**	Not covered	Hospital: 20% **coinsurance**

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	0% **coinsurance**	Not covered	Imaging per occurrence deductible applies prior to the annual deductible: Freestanding: $250 Hospital: $500
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myuhc.com	Outpatient Tier 1 drugs	Retail:$10 **copay**	Not covered	Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 2 drugs	Retail $50 **copay**	Not covered	The **prescription drug deductible** must be met before the **copayment** amount is applied. Limited to a 34-day supply per prescription or refill. If a name brand drug is purchased and a generic drug is available, you pay the difference.
	Outpatient Tier 3 drugs	Retail: 20% **co-insurance** with a $150 **copay** min	Not covered	
	Outpatient Tier 4 drugs	Retail: 30% **co-insurance** with a $300 **copay** min	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% **coinsurance**	Not covered	Outpatient surgery per occurrence deductible applies prior to the annual deductible: Freestanding: $250 Hospital: $500
	Physician/surgeon fees	0% **coinsurance**	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if not a doctor limited to 14%)
If you need immediate medical attention	Emergency room services	$250 **copay** per visit	$250 **copay** per visit	----------none----------
	Emergency medical transportation	0% **coinsurance**	0% **coinsurance**	Ambulance services covered by a local government are not covered.
	Urgent care	0% **coinsurance**	0% **coinsurance**	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 **copay** per admission	Not covered	----------none----------
	Physician/surgeon fee	0% **coinsurance**	Not covered	Assistant surgeon fees limited to 16% of the eligible expense for the surgical procedure.(if

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
				not a doctor limited to 14%)
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 **copay** per visit	Not covered	Treatment for learning disabilities and intellectual disabilities, telephone therapy, services rendered or billed by a school or halfway house, and services not medically necessary are not covered.
	Mental/Behavioral health inpatient services	$750 **copay** per admission	Not covered	
	Substance use disorder outpatient services	$10 **copay** per visit	Not covered	
	Substance use disorder inpatient services	$750 **copay** per admission	Not covered	
If you need help recovering or have other special health needs	Home health care	0% **coinsurance**	Not covered	----------none----------
	Rehabilitation services	0% **coinsurance**	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Habilitative services	0% **coinsurance**	Not covered	Benefits for services for adults are equal to those for rehabilitation and skilled nursing care services. Benefits for services for children are available for treatment of a congenital or genetic birth defect.
	Skilled nursing care	0% **coinsurance**	Not covered	Inpatient for rehabilitation and extended care facility are limited to a combined maximum of 100 days per person, per calendar year.
	Durable medical equipment	0% **coinsurance**	Not covered	----------none----------
	Hospice service	0% **coinsurance**	Not covered	Limited to a prognosis of 6 months or less to live.
If you are pregnant	Prenatal and postnatal care	0% **coinsurance**	Not covered	**Complications of pregnancy** are covered. Prenatal office visits, certain prenatal blood tests and prenatal tobacco cessation counseling may be covered under preventive care. Certain postnatal care is subject to **deductible** and **coinsurance**.
	Delivery and all inpatient services	$750 **copay** per	Not covered	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
		admission		
If your child needs dental or eye care	Eye exam	0% **coinsurance**	Not covered	Limited to one exam per calendar year.
	Glasses	0% **coinsurance**	Not covered	Limited to one pair of lenses and one frame, or a 12 month supply of contact lenses per calendar year.
	Dental check-up	0% **coinsurance**	Not covered	Oral evaluations, cleanings, fluoride treatments, and bitewing x-rays limited to 1 service every 6 months.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (age 18 and over)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care
- Services provided by **non-network providers**, except for emergencies
- Weight-loss programs

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

- Bariatric surgery - limitations may apply
- Hearing aids (under age 18)
- Infertility treatment - limitations may apply
- Manipulative (Chiropractic) Services – limitations may apply
- Private duty nursing (unless it is for home health care)

Your Rights to Continue Coverage:

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

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

For more information on your rights to continue coverage, contact the insurer at (877) 855-6538. You may also contact your state insurance department at (877) 261-8807.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**.

For questions about your rights, this notice, or assistance, you can contact: Maryland Insurance Administration at (877) 261-8807.
Additionally, a consumer assistance program can help you file your appeal. Contact (877) 261-8807 or email: heau@oag.state.md.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (877) 855-7435.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 855-7435.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码(877) 855-7435.

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

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,340
- **Patient pays** $1,200

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	$200
Copays	$80
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,200**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,860
- **Patient pays** $1,540

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
Copays	$1,300
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,540**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-877-855-7435 or visit us at www.uhc.com/xmd.
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 call 1-877-855-7435 to request a copy.