The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to DBM Health Benefits at www.dbm.maryland.gov/benefits or call 410-767-4775 or 1-800-307-8283. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay/copayment, deductible, provider, or other underlined terms see the Glossary at www.dbm.maryland.gov/benefits or call 410-767-4775 or 1-800-307-8283 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**None**	There is no deductible. See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	You do not have to meet deductibles for specific services under this plan. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ or www.dbm.maryland.gov/benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Copayment: **$1,500** Individual/**$3,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See your plan's website address and phone number in the front cover of the Guide to Your Health Benefits for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	You must pay all charges billed by provider	
	Specialist visit	$30 copay per visit	You must pay all charges billed by provider	
	Preventive care/screening/ Immunization	No Charge	You must pay all charges billed by provider	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	You must pay all charges billed by provider	
	Imaging (CT/PET scans, MRIs)	No Charge	You must pay all charges billed by provider	

* For more information about limitations and exceptions, see the Guide to Your Health Benefits at www.dbm.maryland.gov/benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition	Generic drugs	Not included		**Outpatient Prescription Drug coverage is not included in your medical plan.** You elect this coverage separately from your medical plan. The plan is administered by CVS Caremark; you receive a separate ID card and pay a separate premium for prescription coverage. See the State of Maryland's website at www.dbm.maryland/benefits for more details.
	Preferred brand drugs	Not included		
	Non-preferred brand drugs	Not included		
	Specialty drugs	Not included		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	You must pay all charges bill by provider	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Physician/surgeon fees	No Charge	You must pay all charges bill by provider	None
If you need immediate medical attention	Emergency room care	$150 Copay	$150 Copay	
	Emergency medical transportation	No Cost	No Cost	
	Urgent care	$30 copay	You must pay all charges bill by provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	You must pay all charges bill by provider	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Physician/surgeon fees	No Charge	You must pay all charges bill by provider	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.

* For more information about limitations and exceptions, see the Guide to Your Health Benefits at www.dbm.maryland.gov/benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay for office visits	You must pay all charges bill by provider	In Network non-office visits: No Charge
	Inpatient services	No Cost	You must pay all charges bill by provider	Preauthorization is required out-of-network or benefit reduces by 50% of the total cost of the service.
If you are pregnant	Office visits	No Cost	You must pay all charges bill by provider	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No Cost	You must pay all charges bill by provider	
	Childbirth/delivery facility services	No Cost	You must pay all charges bill by provider	
If you need help recovering or have other special health needs	Home health care	No Cost	You must pay all charges bill by provider	Limited to 120 visits per calendar year.
	Rehabilitation services	$30 copay per day	You must pay all charges bill by provider	Limited to 50 combined days per plan year for Speech, Occupational, and Physical Therapy. One day may include multiple visits, but copay will only be applied on a per day basis. Occupational and physical therapy Must be preauthorized after 20th visit; speech therapy must be preauthorized from 1st visit.
	Habilitative services	$30 copay per day	You must pay all charges bill by provider	No limit of treatment for children under 19 with congenital or genetic birth defects including autism, autism spectrum disorder, and cerebral palsy. Must be preauthorized by plan. Over age 19 members visits are limited to 50 combined visits for therapies.
	Skilled nursing care	No Cost	You must pay all charges bill by provider	Limited to 180 days per calendar year
	Durable medical equipment	No Cost	You must pay all charges bill by provider	

* For more information about limitations and exceptions, see the Guide to Your Health Benefits at www.dbm.maryland.gov/benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No Cost	You must pay all charges bill by provider	Preauthorization is required
If your child needs dental or eye care	Children's eye exam	Routine Annual Visit: $0 copay Non-routine: $15 copay PCP/$30 copay Specialist	You must pay all charges bill by provider	Limited to one routine eye exam per year.
	Children's glasses	No Cost	Not Covered	In network limited to 100% of Allowed Benefit
	Children's dental check-up	Not Covered	You must pay all charges bill by provider	Dental covered separately through separate enrollment in either Dental HMO or Dental PPO. Details at www.dbm.maryland.gov/benefits.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Long-term care	• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic Care	• Private Duty Nursing	

* For more information about limitations and exceptions, see the Guide to Your Health Benefits at www.dbm.maryland.gov/benefits.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

.**Does this plan provide Minimum Essential Coverage?** **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

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

* For more information about limitations and exceptions, see the Guide to Your Health Benefits at www.dbm.maryland.gov/benefits.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copay	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$10,040**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copay	$30
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,320**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copay	$0
Hospital (facility) coinsurance	$150
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$150**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

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PAUNA\VA: Kungnagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

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ATANSYON:Si wpale **Kreyol ayisyen (Haitian Creole),** ou kapab benefisye sevis ki gratis pou ede w nan lang paw. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION: Si vous parlez **franc;ais (French),** des services d'aidelinguistique vous soot proposes gratuitement. Veuillez appeler le numero sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

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ATEN<;AO:Se voce fala **portugues (Portuguese),** contate o servic;o de assistencia de idiomas gratuito. Ligue para o numero gratuito listado neste Resumo de Beneficios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE:in caso la lingua parlata sia **l'italiano (Italian),** sono disponibili servizi di assistenza linguistica gratuiti. Chiamate ii numero verde indicato all'intemo di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen lhnenkostenlos sprachliche Hilfsdienstleistungen zur Verfugung. Bitterufen Sie die in dieser Zusammenfassung der Leistungen und Kostenubemahmen (Summary of Benefits and Coverage, SBC) angegebene gebuhrenfreie Rufnummer an.

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PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawatnga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti unegna daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

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OGO\.V: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).