Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services   **Coverage Period: 01/01/2025 – 12/31/2025**

UnitedHealthcare®   **State of Maryland**   **Coverage for: Employee Only | Plan Type: PPO**

⚠ 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, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view 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?	In Network: **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	
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 MedImpact; 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.gov/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 billed 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 billed by provider	None
If you need immediate medical attention	Emergency room care	$150 Copay	$150 Copay	
	Emergency medical	No Cost	No Cost	

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* 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)	
	transportation			
	Urgent care	$30 copay	You must pay all charges billed by provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	You must pay all charges billed 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 billed by provider	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay for office visits	You must pay all charges billed by provider	In Network non-office visits: No Charge
	Inpatient services	No cost	You must pay all charges billed 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 billed 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 billed by provider	
	Childbirth/delivery facility services	No cost	You must pay all charges billed by provider	
If you need help recovering or have other special health needs	Home health care	No cost	You must pay all charges billed by provider	Limited to 120 visits per calendar year.
	Rehabilitation services	$30 copay per day	You must pay all charges billed 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.
	Habilitation services	$30 copay per day	You must pay all charges billed 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

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)	
				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 billed by provider	Limited to 180 days per calendar year.
	Durable medical equipment	No cost	You must pay all charges billed by provider	Preauthorization is required for DME over $1,000
	Hospice services	No cost	You must pay all charges billed 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 billed 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 billed 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

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.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-633-2446.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u> $0
- <u>Specialist</u> copay $0
- Hospital (facility) <u>coinsurance</u>   0%
- Other <u>coinsurance</u>   0%

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

Total Example Cost	$12,700

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 <u>plan's</u> overall <u>deductible</u> $0
- <u>Specialist</u> copay $30
- Hospital (facility) <u>coinsurance</u>   0%
- Other <u>coinsurance</u>   0%

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

Total Example Cost	$5,600

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 <u>plan's</u> overall <u>deductible</u> $0
- <u>Specialist</u> copay $0
- Hospital (facility) <u>coinsurance</u> $150
- Other <u>coinsurance</u>   0%

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

Total Example Cost	$2,800

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 <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.